EXHIBIT A

CSC

Notice of Service of Process

null / ALL
Transmittal Number: 28200380
Date Processed: 12/20/2023

Primary Contact: Bruce Buttaro; Hm Office Lgl SOP Paralegal
Liberty Mutual Insurance Company
175 Berkeley St
Boston, MA 02116-5066

Entity:	Liberty Insurance Corporation Entity ID Number 2538339
Entity Served:	Liberty Insurance Corporation, also known as Liberty Mutual Group, Inc.
Title of Action:	FCS Industries, Inc. (Gary Locklear) vs. Liberty Insurance Corporation, also known as Liberty Mutual Group Inc.
Matter Name/ID:	FCS Industries Inc vs Liberty Mutual Insurance Corporation (13212669)
Document(s) Type:	Summons/Complaint
Nature of Action:	Worker's Compensation
Court/Agency:	3rd Circuit Court, MI
Case/Reference No:	23-016155-CB
Jurisdiction Served:	Michigan
Date Served on CSC:	12/19/2023
Answer or Appearance Due:	28 Days
Originally Served On:	CSC
How Served:	Certified Mail
Sender Information:	Stephen B. Foley, P.C. 313-295-2590

Information contained on this transmittal form is for record keeping, notification and forwarding the attached document(s). It does not constitute a legal opinion. The recipient is responsible for interpreting the documents and taking appropriate action.

To avoid potential delay, please do not send your response to CSC

Stephen B. Foley, P.C.
9900 Pelham Road
Taylor, MI 48180
(313) 295-2590 / (313) 299-2187 (Fax)
sfoley@sbfpc.com

December 15, 2023

Via Certified Mail

Liberty Mutual Insurance Agency
CSC-Lawyers Incorporating Service
3410 Belle Chase Way, Suite 600
Lansing, MI 48911

Re: FCS Industries, Inc., and Freight Consolidation Services, Inc. vs.
Liberty Mutual Insurance Group, Inc.
Wayne County Circuit Case No. 23-016155-CB

Dear Resident Agent:

Enclosed please find the Summons and Complaint which has been filed in Wayne County Circuit Court.

Very truly yours,

Sean S. Cleland

Sean S. Cleland
Attorney at Law

SCC/kk

Original - Court. 2nd Copy - Plaintiff
1st Copy- Defendant 3rd Copy -Return

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	SUMMONS	CASE NO. 23-016155-CB Hon.Muriel Hughes

Court telephone no.: 313-224-2415

Plaintiff's name(s), address(es), and telephone no(s)	v	Defendant's name(s), address(es), and telephone no(s).
FCS Industries, Inc. and Freight Consolidation Services, Inc.		Liberty Insurance Corporation, also known as Liberty Mutual Group, Inc.
Plaintiff's attorney, bar no., address, and telephone no Sean S. Cleland 55856 9900 Pelham Rd Taylor, MI 48180-3852		

Instructions: Check the items below that apply to you and provide any required information. Submit this form to the court clerk along with your complaint and, if necessary, a case inventory addendum (form MC 21). The summons section will be completed by the court clerk.

Domestic Relations Case

☐ There are no pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.

☐ There is one or more pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint. I have separately filed a completed confidential case inventory (form MC 21) listing those cases.

☐ It is unknown if there are pending or resolved cases within the jurisdiction of the family division of the circuit court involving the family or family members of the person(s) who are the subject of the complaint.

Civil Case

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035

☐ MDHHS and a contracted health plan may have a right to recover expenses in this case. I certify that notice and a copy of the complaint will be provided to MDHHS and (if applicable) the contracted health plan in accordance with MCL 400.106(4).

☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.

☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in ☐ this court, ☐ _____ Court, where it was given case number _____ and assigned to Judge _____.

The action ☐ remains ☐ is no longer pending.

Summons section completed by court clerk. **SUMMONS**

NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons and a copy of the complaint to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state).
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.
4. If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

Issue date	Expiration date*	Court clerk
12/14/2023	3/14/2024	Carla Keefe

Cathy M. Garrett- Wayne County Clerk.

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

SUMMONS
Case No. : **23-016155-CB**

PROOF OF SERVICE

TO PROCESS SERVER: You must serve the summons and complaint and file proof of service with the court clerk before the expiration date on the summons. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE OF SERVICE / NONSERVICE

☐ I served ☐ personally ☐ by registered or certified mail , return receipt requested, and delivery restricted to the addressee(copy of return receipt attached) a copy of the summons and the complaint, together with the attachments listed below, on:

☐ I have attempted to serve a copy of the summons and complaint, together with the attachments listed below, and have been unable to complete service on:

Name	Date and time of service
Place or address of service	
Attachments (if any)	

☐ I am a sheriff,deputy sheriff, bailiff, appointed court officer or attorney for a party.

☐ I am a legally competent adult who is not a party or an officer of a corporate party. I declare under the penalties of perjury that this certificate of service has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Service fee	Miles traveled	Fee	
$	$	$	
Incorrect address fee	Miles traveled	Fee	**Total fee**
$	$	$	**$**

Signature

Name (type or print)

ACKNOWLEDGMENT OF SERVICE

I acknowledge that I have received service of the summons and complaint, together with

_____ on _____
Attachments (if any) Date and time

_____ on behalf of _____.

Signature
_____

MCL 600.1910, MCR 2.104, MCR 2.105

STATE OF MICHIGAN 3rd JUDICIAL CIRCUIT COUNTY OF WAYNE	VERIFICATION OF BUSINESS COURT ELIGIBILITY AND NOTICE OF ASSIGNMENT	CASE NO. 2023- CB

Court address: 2 Woodward Ave., Detroit, MI 48226

Plaintiff(s)		Defendant(s)
FCS Industries, Inc., and Freight Consolidation Services, Inc.	v	Liberty Insurance Corporation, also known as Liberty Mutual Group, Inc.

I am the attorney for the [check one] ☑ plaintiff ☐ defendant and per *MCR 2.114(B)(2) and MCR 2.114(D)* declare to the best of my information, knowledge, and belief that this case meets the statutory requirements to be assigned to the business court, *MCR 2.112(O),MCL 600.8031 et seq.*, and request assignment to the Business Court for the following reasons:

[***Both Sections 1 and 2 must be completed to be accepted by the Court (check all that apply)***]

1. **Parties.** This is a qualifying business or commercial dispute as defined by *MCL 600.8031(1)(c)* because,

☑ all of the parties are business enterprises

☐ one or more of the parties is a business enterprise and the other parties are its or their present or former owners, managers, shareholders, members, directors, officers, agents, employees, suppliers, or competitors, and the claims arise out of those relationships

☐ one of the parties is a non-profit organization, and the claims arise out of that party's organizational structure, governance, or finances

☐ It is an action involving the sale, merger, purchase, combination, dissolution, liquidation, organizational structure, governance, or finances of a business enterprise.

AND

2. **Actions.** This business or commercial action as defined by *MCL 600.8031(2)* involves,

☐ information technology, software, or website development, maintenance, or hosting

☐ the internal organization of business entities and the rights or obligations of shareholders, partners, members, owners, officers, directors, or managers

☐ contractual agreements or other business dealings, including licensing, trade secret, intellectual property, antitrust, securities, noncompete, nonsolicitation, and confidentiality agreements if all available administrative remedies are completely exhausted, including but not limited to, alternative dispute resolution processes prescribed in the agreements

☐ commercial transaction, including commercial bank transactions

☑ business or commercial insurance policies

☐ commercial real property

☐ other type of business or commercial dispute (explain):

December 14, 2023
Date

Sean Cleland
Signature

Sean Cleland P55856
Name (type or print) Bar no.

STATE OF MICHIGAN

IN THE 3RD CIRCUIT COURT FOR THE COUNTY OF WAYNE

FCS Industries, Inc. and Freight Consolidation Services Inc.,

Plaintiff,

Vs.

Liberty Insurance Corporation, also known as Liberty Mutual Group Inc.,

Defendant.

Case No. 23- CB
HON.

This case meets the statutory requirements to be assigned to the business court pursuant to MCR 2.112(O)(1)

/

SEAN S. CLELAND, (P-55856)
STEPHEN B. FOLEY, (P-27274)
Attorneys for Plaintiff
Stephen B. Foley, P.C.
9900 Pelham Road
Taylor, MI 48180
(313) 295-2590 / (313) 295-2597 (Fax)
scleland@sbfpc.com
sfoley@sbfpc.cm

/

COMPLAINT

There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint.

NOW COMES Plaintiffs, FCS Industries, Inc. and Freight Consolidation Services Inc., by its attorneys, Steven B. Foley, P.C., and for its Complaint, states as follows:

JURISDICTION AND VENUE

1. Plaintiff FREIGHT CONSOLIDATION SERVICES INC., a Delaware Corporation with its principal place of business in Taylor, Michigan, County of Wayne, is a subsidiary company of Plaintiff FCS INDUSTRIES, INC., also a Delaware Corporation with its principal place of business in Taylor, Michigan, County of Wayne (collectively referred to as "Plaintiffs").

2. Defendant, LIBERTY INSURANCE CORPORATION, also known as LIBERTY MUTUAL GROUP, INC. ("LIBERTY"), is an insurance business licensed to conduct business in the State of Michigan that insures persons, property, and risk within the State of Michigan and that is doing and conducting business in the State of Michigan, County of Wayne.

3. Venue is appropriate pursuant to MCL 600.1621 because Defendant does business in Wayne County, and Plaintiffs' principal place of business is in Wayne County.

4. This Court has jurisdiction pursuant to MCR 2.605(A)(2) because there is an actual controversy within this Court's jurisdiction necessitating a declaration of legal rights between the parties.

5. Further, this Court has jurisdiction because the amount in controversy exceeds twenty-five thousand dollars ($25,000.00), exclusive of interest and costs.

FACTUAL ALLEGATIONS

6. On or about November 1, 2007, FCS INDUSTRIES, INC. FCS entered into an insurance agreement with LIBERTY in which LIBERTY was to provide Workers Compensation excess insurance coverage for employees of FREIGHT CONSOLIDATION SERVICES INC. for the time period of November 1, 2007, through November 1, 2008 ("POLICY"). A copy of the POLICY is attached to this Complaint.

7. The POLICY provides that:

INFORMATION PAGE

ITEM 6 –

Insured's Retention for each accident or each employee disease $500,000.00.

GENERAL SECTION

PART ONE – WORKERS COMPENSATION INSURANCE

A. We will indemnify you for loss as a qualified self-insurer under the Workers Compensation Law in excess of your retention as stated in Item 6 on the Information Page but not for more than the applicable limit of indemnity stated in Item 7 of the Information Page.

B. Loss means amounts you have actually paid as a self-insurer under the Workers Compensation Law.

C. This excess insurance applies to losses you have paid as a qualified self-insurer under the Workers Compensation Law for bodily injury by accident or bodily injury for disease including resulting death, provided:

1. the bodily injury by accident occurs during the policy period.

PART FOUR – YOUR RETENTION AND OUR LIMIT OF INDEMNITY

D. Accident:

1. Accident means each accident or occurrence or series of accidents or occurrences arising out of any one event.
2. An accident is deemed to end 72 hours after the event commences. Each subsequent 72 hour is deemed to be a separate incident.

Part Seven – Conditions –

D. Payment of Loss to Insured:

We will indemnify you for any loss under this policy as follows:

1. ...Our indemnity will be made at monthly intervals after we have received proof of payment by you.

8. On February 8, 2008, and February 10, 2008, Gary Locklear ("CLAIMANT"), an employee of FREIGHT CONSOLIDATION SERVICES INC., sustained an injuries, including injuries to his neck and back, while working at his employer's location in Sterling Heights, Michigan (hereinafter "2008 ACCIDENT").

9. On or about February 8, 2008 Plaintiffs opened a workers compensation file for Mr. Locklear pertaining to the ACCIDENT.

10. At no time subsequent to February 10, 2008, did CLAIMANT suffer an injury as a result of accident at work or otherwise.

11. Mr. Locklear continued to work after the ACCIDENT, but on restricted duty that limited him to work from his home.

12. On July 23, 2008 CLAIMANT underwent a lumbar laminectomy and discectomy as a result of his injuries from the ACCIDENT.

13. CLAIMANT continued to work on restricted duty after the July 23, 2008 surgery and continued to take pain medications for his injuries.

14. Between September 2008 and January 2009 CLAIMANT was able to reduce his consumption of pain medications after his lumbar surgery and as a result his neck pain became more evident.

15. By January 2009, CLAIMANT's medical providers began treating CLAIMANT for increasing back pain by increasing his intake of pain medication, performing injections and scheduling an MRI.

16. On March 27, 2009 Plaintiff sought treatment for his neck pain from another medical provider and indicated that he had been suffering from neck pain since the ACCIDENT.

17. On April 27, 2009, an MRI of the cervical spine and right shoulder revealed several disc herniations and a full thickness rotator cuff tear.

18. On June 1, 2009, CLAIMANT underwent a cervical discectomy and fusion surgery. The operative report for this surgery indicates that Plaintiff had been experiencing neck pain for greater than one year.

19. Due to his cervical and lumbar issues Plaintiff did not return to work after the June 1, 2009 surgery based upon the advice of his physicians.

20. In September 2010, CLAIMANT underwent right shoulder surgery to repair the torn rotator cuff identified in the April 27, 2009, MRI.

21. Since September 2010, CLAIMANT has continued to require treatment and additional surgeries because of the 2008 ACCIDENT, including a 2011 lumbar fusion, a 2013 lumbar laminectomy, and in February 2021 cervical and lumbar spinal fusions.

22. Between February 2008 and 2020, including but not limited to 2011, 2013 and 2018, Plaintiffs provided LIBERTY with self-insured loss run reports on its workers compensation files including the claim pertaining to CLAIMANT, that provided information to LIBERTY that included, but is not limited to, the costs and indemnity incurred on the claim to date.

23. Between February 2008 and 2020, including but not limited to 2011, 2013 and 2018 LIBERTY conducted audits of Plaintiff's workers compensation files, including the to-date complete file of CLAIMANT, and received reports on the status of the Locklear claim from Plaintiffs.

24. In 2013 a LIBERTY representative named Dennis Mincin conducted an audit of the Locklear file.

25. In November 2018 LIBERTY representative Dennis Mincin requested that Plaintiffs report the Locklear claim to LIBERTY since the case had reached a reporting trigger. In response, Plaintiffs reported the case to LIBERTY.

26. In November 2020, Plaintiffs' claims representative notified LIBERTY that Plaintiffs had exhausted the self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for bodily injury resulting from the 2008 ACCIDENT and provided LIBERTY with proof of payments made by Plaintiffs for the injuries incurred due to the 2008 ACCIDENT.

27. On or about February 20, 2021, LIBERTY informed Plaintiffs that it was taking the position that the injuries and treatments pertaining to CLAIMANT's neck, cervical and right shoulder were not related to the 2008 ACCIDENT and denied coverage to Plaintiffs.

28. In March and April 2021, Plaintiffs provided LIBERTY with additional documentation of proof of payments it had made for the injuries incurred due to the 2008 ACCIDENT, which indicated that Plaintiffs had incurred approximately $61,027.01 in losses above its self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injury due to the 2008 ACCIDENT.

29. On or about August 27, 2021, Plaintiffs provided LIBERTY with the Affidavit of CLAIMANT, which supports the allegations made in this Complaint and indicates that CLAIMANT's injuries and treatments pertaining to his neck, cervical and right shoulder were related to the 2008 ACCIDENT. A copy of the Affidavit of the CLAIMANT is attached to this Complaint.

30. On October 14, 2022 Plaintiffs provided LIBERTY with additional documentation of payments it had made for the injuries incurred due to the 2008 ACCIDENT, which indicated that Plaintiffs had incurred approximately $164, 468.22 in losses above its self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injury due to the 2008 ACCIDENT.

31. On April 14, 2023 Plaintiffs provided LIBERTY with additional documentation of payments it had made for the injuries incurred due to the 2008 ACCIDENT, which indicated that Plaintiffs had incurred approximately $181,736.84 in losses above its self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injury due to the 2008 ACCIDENT.

32. On October 13, 2023 Plaintiffs provided LIBERTY with additional documentation of payments it had made for the injuries incurred due to the 2008 ACCIDENT, which indicated that Plaintiffs had incurred approximately $197,435.39 in losses above its self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injury due to the 2008 ACCIDENT.

33. Through November 21, 2023, Plaintiffs have incurred a total loss of approximately $199,769.08 above the self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injury from the 2008 ACCIDENT.

34. LIBERTY continues to deny coverage to Plaintiffs and maintains the position that CLAIMANT's injuries and treatments pertaining to his neck, cervical and right shoulder were not related to the 2008 ACCIDENT and as a result denies that Plaintiffs have reached the self-insured retention of FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] for workers compensation payments made for CLAIMANT's bodily injuries.

COUNT I – DECLARATORY RELIEF REQUESTED:

35. Plaintiffs hereby incorporate Paragraphs 1-34 by reference as if fully restated herein.

36. The 2008 ACCIDENT occurred within the POLICY period.

37. CLAIMANT's injuries as set forth in this Complaint and attachments thereto are the result of the 2008 ACCIDENT.

38. Plaintiffs have paid over FIVE HUNDRED THOUSAND DOLLARS [$500,000.00] pursuant to the Workers Compensation Laws of Michigan for bodily injuries caused by the 2008 ACCIDENT.

39. At all times relevant, Plaintiffs have complied with its obligations under the Policy, including its obligations to provide LIBERTY with proof of workers compensation payments made for bodily injuries caused by the 2008 ACCIDENT.

40. LIBERTY is obligated under the POLICY to indemnify Plaintiffs for workers compensation payments made by Plaintiffs for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount.

41. LIBERTY is obligated under the POLICY to indemnify Plaintiffs at monthly intervals for amounts Plaintiffs have paid for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount.

42. MCL 500.2006 provides for the addition of interest on claims when an insurer has failed to pay on a claim within 60 days of receiving satisfactory proof of loss.

43. LIBERTY is obligated under MCL 500.2006 to pay interest on indemnity payments it owes to Plaintiffs for amounts that Plaintiffs have paid for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount.

WHEREFORE, Plaintiffs respectfully request a declaratory judgment providing the following judicial declarations:

A. The 2008 ACCIDENT occurred within the POLICY period;
B. All of CLAIMANT's bodily injuries set forth in this Complaint, including injuries to CLAIMANT's neck, cervical and right shoulder, are the result of the 2008 ACCIDENT;
C. Plaintiffs have exhausted the $500,000.00 self-insured retention obligation for workers compensation payments made for bodily injuries caused by the 2008 ACCIDENT;
D. Plaintiffs have complied with all of its obligations under the POLICY;
E. LIBERTY is obligated to indemnify Plaintiffs for workers compensation payments made or to be made by Plaintiffs for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount;
F. LIBERTY is obligated to pay Plaintiffs interest pursuant to MCL 500.2006 for workers compensation payments Plaintiffs made for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount;
G. Grant all other appropriate and equitable relief that the Court deems proper.

COUNT II – BREACH OF CONTRACT

44. Plaintiffs hereby incorporates Paragraphs 1-43 by reference as if fully restated herein.

45. LIBERTY has failed to indemnify Plaintiffs for workers compensation payments Plaintiffs have made for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount.

46. LIBERTY's failure to indemnify Plaintiffs for workers compensation payments Plaintiffs have made for bodily injuries caused by the 2008 ACCIDENT in excess of the $500,000.00 self-insured retention amount is a breach of LIBERTY's contractual obligations under the POLICY.

47. LIBERTY's breach of contract entitles Plaintiffs to interest on indemnity amounts owed by LIBERTY to Plaintiffs pursuant to MCL 500.2006.

WHEREFORE, Plaintiffs respectfully request this this Honorable Court enter a judgment against LIBERTY as follows:

(a) Requiring LIBERTY to indemnify Plaintiffs for the amount of workers compensation payments Plaintiffs have paid for bodily injuries caused by the 2008 ACCIDENT in excess of its $500,000.00 self-insured retention amount;
(b) Requiring LIBERTY to pay to Plaintiffs interest pursuant to MCL 500.2006 on amounts LIBERTY owes to Plaintiffs for losses Plaintiffs incurred due to workers compensation payments Plaintiffs have made for bodily injuries caused by the 2008 ACCIDENT in excess of its $500,000.00 self-insured retention amount;
(c) All other appropriate and equitable relief that the Court deems proper, including but not limited to interest, taxable costs, and attorney fees to the extent recoverable under the law.

/s/Sean S. Cleland
Stephen B. Foley, P.C.
Attorneys for Plaintiff
9900 Pelham Road
Taylor, MI 48180
(313) 295-2590 / (313) 295-2597 (Fax)
scleland@sbfpc.com
(P-55856)

Dated: December 14, 2023

EXHIBIT 1

Liberty Mutual

Liberty Insurance Corporation

Excess Insurance Policy
For Self-Insurer of
Workers Compensation and
Employers Liability

INFORMATION PAGE

ACCOUNT NO.	SUB ACCT. NO.
4-437875	0000

POLICY NO.	TD/CD	SALES OFFICE	CODE	SALES REPRESENTATIVE	CODE	N/R	1ST YEAR
EW7-14N-437875-037	92/9	Farmington Hills	440	Fannon	6502	1	2007

Item 1. Name of Insured: F C S Industries Inc

Item 2. Mailing Address: 9850 Pelham Rd
Taylor MI 48180

Item 3. Policy Period: From Mo. 11 Day 01 Year 2007 To Mo. 11 Day 01 Year 2008
12:01 A.M., standard time at the address of the insured as stated herein.

Item 4. Cancellation Notice: _____ days written Notice, Subject to Part Seven – Conditions, Paragraph L

Item 5. Covered State(s) and Territory(s)

a) Workers Compensation Insurance: Part One of the policy applies to the Insured's obligations under the Workers Compensation Law of the States listed here: MI

b) Employers Liability Insurance: Part Two of the policy applies to the Insured's obligations in each state listed in Item 5A.

c) Other States Insurance: Part Three of the policy applies to the Insured's obligations in all other States, except those listed here:

Item 6. Insured's Retention for each accident or each employee for disease $ 500,000

Item 7. A. Insurer's Limit of Indemnity for each accident or each employee for disease:

1. For Workers Compensation Insurance	$	Statutory
2. For Employers Liability Insurance	$	1,000,000
3. For Workers Compensation and Employers Liability Insurance Combined	$	N/A

B. Insurer's Aggregate Limit of Indemnity each policy period: $ Statutory

Item 8. The premium for this policy will be determined on the basis of the information shown below, subject to verification and change by audit:

Total Estimated Annual Remuneration	Rate per $100 of Remuneration		Estimated Annual Premium
28,105,000	.105	$	29,510
Total Estimated Annual Premium		$	29,510
Advance Premium for this Policy		$	29,510
Minimum Annual Premium		$	29,510
Terrorism Risk Insurance Act		$	0

This policy, including all endorsements therewith, is hereby countersigned by Michele A Opie
Authorized Representative

Work Units	Term Oper.	Audit Basis	Periodic Payment	Rating Basis	Pol. H.G.	Home State	Class Code	Renewal of:
	11/9/07 TJD	1		NR		MI		NEW

GPO 4239

EXCESS INSURANCE POLICY FOR SELF-INSURER OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT COVERAGE ENDORSEMENT

This endorsement applies only to work subject to the Longshoremen's and Harbor Workers' Compensation Act which is incidental to a state shown in Item 5a of the Information Page. There is no known exposure.

For the purposes of this endorsement only, the definition of workers compensation law includes the Longshoremen's and Harbor Workers' Compensation Act (33 USC Sections 901-950) and any amendment to that Act that is in effect during the policy period.

This endorsement does not apply to work subject to the Defense Base Act, the Outer Continental Shelf Lands Act, or the Non Appropriated Fund Instrumentalities Act.

This endorsement is executed by the LIBERTY INSURANCE CORPORATION

Premium $

Effective Date Expiration Date

For attachment to Policy No. EW7-14N-437875-037

Audit Basis

Issued To

SECRETARY PRESIDENT

Countersigned by

Authorized Representative

Issued Sales Office and No. End. Serial No. 1

GPO 4233 R2
(Ed. 8/93)

EXCESS INSURANCE POLICY FOR SELF INSURER OF WORKERS COMPENSATION AND EMPLOYERS LIABILITY

AMENDATORY ENDORSEMENT

Part One – Workers Compensation Insurance of this policy is amended by adding the following provision:

F. As used in this contract, the word "indemnify" shall mean "reimburse." The words "indemnify" and "indemnification" shall mean "reimbursement."

Part Two – Employers Liability Insurance of this policy is amended by adding the following provision to Part C:

C. As used in this contract, the word "indemnify" shall mean "reimburse." The words "indemnity" and "indemnification" shall mean "reimbursement."

The Payment of Loss to Insured, Condition D in Part Seven – Conditions of this policy is amended with the following provisions:

D. **Payment of Loss to Insured**

We will indemnify you for any loss under this policy as follows:

1. For PART ONE – Workers' Compensation Insurance and PART THREE – Others States Insurance – we will indemnify you for all benefits paid by you as required by the Workers' Compensation Law after we have received proof of payment by you. Workers' Compensation awards shall not be settled on a lump sum basis without our prior written consent.

2. For PART TWO – Employers' Liability Insurance – if damages are awarded which you legally must pay, you shall pay such damages. We will indemnify you upon proof of payment of such damages by you.

Schedule of States where Applicable:

This endorsement is executed by the LIBERTY INSURANCE CORPORATION

Premium $

Effective Date Expiration Date

For attachment to Policy No. EW7-14N-437875-037

Audit Basis

Issued To

Dexter R. Legg
SECRETARY

Edward F. Kelly
PRESIDENT

Countersigned by _____
Authorized Representative

Issued Sales Office and No. End. Serial No. 2

GPO 4323
(1/1/92)

Liberty Insurance Corporation
175 Berkeley Street
Boston, Massachusetts 02117-0140

Excess Insurance Policy
For Self-Insurer of
Workers Compensation and Employers Liability

This policy provides Excess Insurance for Self-Insurers of Workers Compensation and Employers Liability. It is an indemnity policy.

Throughout this policy the words "you" and "your" refer to the insured shown in Item 1 of the Information Page. The words "we", "us" and "our" refer to the Company providing the excess insurance.

Please read the entire policy carefully.

In return for the payment of the premium and subject to all the terms and conditions of this policy we agree with you as follows:

GENERAL SECTION

A. THE POLICY

This is a contract of excess insurance between you and us. It includes the Information Page. The only agreements relating to this excess insurance are stated in the policy. The terms of this policy may not be changed or waived except by an endorsement issued by us to be part of this policy.

B. POLICY PERIOD

This policy is effective for the period stated in Item 3 of the Information Page.

C. WHO IS INSURED

The Insured is named in Item 1 of the Information Page. If you are a partnership or joint venture, each of your partners or members of the joint venture is insured but only in their capacity as an employer of employees of the partnership or joint venture.

D. WORKERS COMPENSATION LAW

Workers Compensation Law means the workers or workmens compensation law and occupational disease law of each state named in Item 5a of the Information Page. It includes any amendments to that law which are in effect during the term of this policy. It does not include the provisions of any law that provides non-occupational disability benefits.

E. QUALIFIED SELF-INSURER

You represent that you are a duly qualified self-insurer under the Workers Compensation Law of each state named in Item 5a of the Information Page and will continue to maintain such qualifications throughout the term of this policy. If you should terminate such qualifications or if your qualification as a self-insurer is cancelled or revoked while this policy is in effect, the amounts payable under this policy will not exceed the amounts which would have been payable if such qualifications had been maintained in full force and effect.

F. STATE

State means any state of the United States of America and the District of Columbia.

PART ONE - WORKERS COMPENSATION INSURANCE

A. We will indemnify you for loss as a qualified self-insurer under the Workers Compensation Law in excess of your retention as stated in Item 6 on the Information Page but not for more than the applicable limit of indemnity stated in Item 7 of the Information Page.

B. Loss means amounts you have actually paid as a self-insurer under the Workers Compensation Law.

C. This excess insurance applies to losses you have paid as a qualified self-insurer under the Workers Compensation Law for bodily injury by accident or bodily injury by disease including resulting death, provided:

1. the bodily injury by accident occurs during the policy period; or

2. the bodily injury by disease is caused by, or aggravated by the conditions of employment by you. The employee's last day of last exposure to those condition causing or aggravating such bodily injury by disease must occur during the policy period.

D. We will not indemnify you for any payments made by you in excess of the benefits regularly required by the Workers Compensation Law if such excess payments are required because:

1. of your serious and willful misconduct;

2. you employ an employee in violation of law;

3. you fail to comply with a health or safety law or regulation;

4. you discharge, coerce, or otherwise discriminate against any employee in violation of the Workers Compensation Law; or

5. you violate or fail to comply with any Workers Compensation Law.

E. We will not indemnify you for any loss arising out of any operations for which you have rejected any Workers Compensation Law.

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. We will indemnify you for loss as a qualified self-insurer of employers liability in excess of your retention set forth in Item 6 on the Information Page but not for more than the applicable limit of indemnity stated in Item 7 of the Information Page.

B. We will only indemnify you if the original suit and any related legal actions for damages for bodily injury by accident or disease is brought in the United States of America, its territories or possessions or Canada.

C. Loss means amounts which you have actually paid as damages as a self-insurer of employers liability because of bodily injury by accident or bodily injury by disease. Bodily injury includes death resulting therefrom.

D. This excess insurance applies to losses you have paid as a qualified self-insurer of employers liability for bodily injury which arises out of and in the course of the injured employee's employment by you, provided:

1. the bodily injury by accident occurs during policy period; or

2. the bodily injury by disease is caused by, or aggravated by the conditions of employment by you. The employee's last day of last exposure to those conditions which cause or aggravate such bodily injury by disease must occur during the policy period; and

the employment is necessary or incidental to work conducted by you in a state listed in Item 5a of the Information Page.

E. **DAMAGES INCLUDE AMOUNTS YOU HAVE PAID:**

1. for which you are liable to a third party by reason of a claim, suit or proceeding against you by that third party to recover the damages claimed against that third party as a result of injury to your employee;

2. for care and loss of services because of your injured employee;

3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided such amounts in 1, 2 and 3 are the direct result of bodily injury which arises out of, and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of, and in the course of employment, claimed against you in a capacity other than as employer.

F. **EMPLOYERS' LIABILITY INSURANCE EXCLUDES:**

1. liability assumed under a contract;

2. punitive or exemplary damages;

3. bodily injury to an employee while employed in violation of law;

4. bodily injury intentionally caused or aggravated by you or at your direction;

5. bodily injury occurring outside the United States of America, its territories or possessions, or Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily working outside these countries for you;

6. damages arising out of your discharge of, coercion of, or discrimination against any employee in violation of the law;

7. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law; or

8. damages arising out of operations for which you:

   (a) have violated or failed to comply with any workers compensation law, or

   (b) have rejected any workers compensation law.

PART THREE - OTHER STATES INSURANCE

A. This policy applies in the states not listed in Item 5a of the Information Page (other states), but only if your employee is injured in a state not listed in Item 5a and only if:

   1. the injured employee was within the scope of the employee's employment by you;

   2. you are not insured or self-insured in the state where your employee is injured;

   3. the other state is not listed as an exception in Item 5c of the Information Page;

   4. the injured employee is regularly employed in a state listed in Item 5a of the Information Page;

   5. the work in the other state is incidental to work in a state listed in Item 5a of the Information Page; and

   6. the work of the injured employee was not at a permanent or fixed location of yours which is subject to the Workers Compensation Law of the other state.

B. For any workers compensation benefits awarded under the law of any other state except those listed in Item 5c of the Information Page, we will indemnify you but only to the extent that the other state benefits do not exceed the benefits which would have been paid to the injured employee under the workers compensation law of the state in which the employee is regularly employed.

C. For any workers compensation benefits awarded under the U.S. Longshoremen's and Harbor Workers' Compensation Act, except if such Act is listed in Item 5c of the Information Page, we will indemnify you but only to the extent that those benefits do not exceed the benefits which would have been paid to the injured employee under the workers compensation law of the state in which the employee is regularly employed.

PART FOUR - YOUR RETENTION AND OUR LIMIT OF INDEMNITY

A. Your Retention:

You shall pay from your own account without other insurance, all loss up to the amount stated in Item 6 of the Information Page as Insured's Retention.

B. Our Limit of Indemnity:

1. Our Aggregate Limit of Indemnity, shown in Item 7B of the Information Page, is the most we will indemnify you for all loss over the amount stated as Insured's Retention in Item 6 of the Information Page during the policy period.

2. Subject to the Aggregate Limit of Indemnity described in paragraph 1, we will indemnify you for loss over the amount stated as Insured's Retention in Item 6 of the Information Page. Our limit of indemnity for Workers Compensation Insurance will not exceed the limit stated in Item 7A1 of the Information Page. Our limit of indemnity for Employers Liability Insurance will not exceed the limit stated in item 7A2 of the Information Page. Subject to 7A1 and 7A2, our total indemnity for Workers Compensation and Employers Liability Insurance combined for any one accident will not exceed the limit stated in item 7A3 of the Information Page.

C. How Retention and Limit of Indemnity Apply:

Your Retention and Our Limit of Indemnity as stated on the Information Page apply to losses you have paid as a qualified self-insurer of Workers Compensation and Employers Liability as follows:

1. To one or more employees because of bodily injury or death in any one accident.

2. To any one employee for bodily injury or death by disease.

The inclusion of more than one legal entity as an Insured in Item 1 of the Information Page will not increase your Retention or our limit of Indemnity.

D. Accident:

1. Accident means each accident or occurrence or series of accidents or occurrences arising out of any one event.

2. An accident is deemed to end 72 hours after the event commences. Each subsequent 72 hour is deemed to be a separate accident.

E. Disease:

Disease is an accident only if it results directly from bodily injury by accident.

PART FIVE - CLAIM EXPENSES

A. Claim expense means your litigation cost, interest required by law on awards or judgments, and your claim investigation or legal expense which can be directly allocated to a specific claim. Claim expense excludes: salaries and travel expenses of your employees, annual retainers, overhead and any fees you paid for claim administration.

B. We will indemnify you for a portion of the claim expenses you pay. The portion we will indemnify will equal the percentage of the claim expense determined by the ratio of loss paid by us to the total amount of the loss (up to the applicable limit of indemnity).

C. We have no duty to investigate, handle, settle or defend any claim, proceeding or suit against you.

PART SIX - PREMIUM

A. Premium Determination:

Premium will be determined on the basis of the entire payroll and other remuneration paid or payable to all of your employees and officers.

Remuneration includes:

1. Payroll, salaries, commissions, bonuses, overtime pay, pay for holidays, vacations, pay for piece work, payments under profit sharing or incentive plans, the value of lodging, apartments, and meals received by your employees as part of their pay, and the value of store certificates, merchandise, credits, or any other substitute for money received by your employees as part of their pay.

2. The entire amount received by any other person engaged in work which could make you liable under Part One - Workers Compensation of this policy. This section 2 will not apply if you provide us with proof that the employers of these persons had lawfully secured their workers compensation obligations.

B. Estimated Premium:

The total estimated annual premium shown on the Information Page is an estimate and is subject to verification by inspection or audit.

C. Advance Premium:

The advance premium shown in Item 8 of the Information Page is a deposit premium payable at the inception of this policy and will be retained by us until the end of the policy period.

D. Final Premium:

The final premium will be determined at the end of the policy period by use of the actual, instead of estimated, premium base. If the final premium exceeds the premium previously paid, you will promptly pay the excess to us. If the final premium is less than premium previously paid, we will promptly return the balance to you. The final premium will not be less than the Minimum Annual Premium stated in Item 8 of the Information Page.

E. Termination of Policy:

If the earned premium upon termination of this policy exceeds premium previously paid, you will pay the excess to us. If such earned premium is less than premium previously paid, we will return the balance to you.

PART SEVEN - CONDITIONS

A. Notice of Accident:

1. You shall give prompt written notice to us if a claim for an injury or disease occurs which appears to involve indemnity by us.

2. You shall also give prompt written notice to us if any injury of the following type occurs:

   (a) a death;

   (b) an amputation of a major extremity;

   (c) any serious head or brain injury (including skull fracture or loss of sight of either or both eyes);

   (d) any injury to the spinal cord;

   (e) any disability where it appears that there will be disability of more than one year; or

   (f) any second or third degree burn of 25% or more of the body.

3. The notice of accident given to us shall contain complete details of the injury, disease, or death. If a suit, claim or other proceeding is commenced because of an injury listed in Section 2 above or on any injury which appears to involve indemnity by us, you shall give us:

   (a) all notices and legal papers related to the claim, proceeding or suit, or copies of these notices and legal papers; and

   (b) copies of reports of investigations you make, or have made on such claims, proceedings, or suits.

B. Duties of Insured and Insurer:

1. We have no duty to investigate, handle, settle or defend any claims, suits, or proceedings against you.

2. We have the right and shall be given the opportunity to associate with you in the defense, investigation, or settlement of any claim, suit or proceeding which appears to involve indemnity by us. In such association, you shall cooperate with us in all aspects of the defense, investigation, or settlement.

C. Appeals:

If you do not appeal an award or judgment which exceeds your Retention, we have the right to appeal at our own cost and expense and shall be liable for costs, disbursement and interest related to the appeal. If we elect to appeal, our liability on the award or judgment shall not exceed the applicable limit of indemnity in Item 7 of the Information Page plus the cost and expense of the appeal.

D. Payment of Loss to Insured:

We will indemnify you for any loss under this policy as follows:

1. For Part One - Workers Compensation Insurance and Part Three - Other States Insurance - we will pay all benefits required of you by the Workers Compensation Law. Our indemnity will be made at monthly intervals after we have received proof of payment by you. Workers Compensation awards shall not be settled on a lump sum basis without our prior written consent.

2. For Part Two - Employers Liability Insurance - if damages are awarded which you legally must pay, you shall pay such damages. Our indemnity will be made within 30 days after we have received proof of payment by you.

E. Subrogation - Recovery From Others:

1. We have the right to recover all payments which we have made to you from anyone liable for such loss. If you recover from anyone liable for such loss, we shall first be reimbursed from such recovery to the extent of our payments to you.

2. If you do not begin an action or proceeding to recover damages from anyone liable for a loss paid by us, we have your right to recover damages from anyone liable for such loss. You will do everything necessary to protect those rights and will help us to enforce them. Any such recovery by us will be allocated as follows:

   (a) we will be reimbursed for all of our payments under this policy;

   (b) any balance which remains after we have been reimbursed will be paid to you.

3. Expenses of all proceedings to recover from anyone liable for injury covered by this policy will be allocated between you and us in the ratio represented by the allocation of any damages which have been recovered.

4. If there is no recovery in proceedings initiated solely by us, we will bear the expenses of those proceedings.

5. If you have insurance coverage in excess of our limit of indemnity under this policy and if a subrogation recovery is obtained from anyone liable for loss, any such excess carrier will be reimbursed for any loss paid in excess of our limit of indemnity before any reimbursement to us or to you.

6. If you have no insurance coverage in excess of our limit of indemnity and if there is subrogation recovery in excess of our limit of indemnity, you will be reimbursed to the extent you have paid any loss in excess of our limit of indemnity before we are reimbursed.

F. Action Against Insurer:

You will have no right of action against us unless you have complied with all the terms and conditions of this policy.

G. Other Insurance:

If you have other insurance, reinsurance, indemnity, or a reimbursement agreement applicable to a loss for which you would be indemnified under this policy, the indemnity under this policy will apply in excess of such other insurance, reinsurance, indemnity or reimbursement and will not contribute to such a loss with such other insurance, reinsurance, indemnity or reimbursement. This condition does not apply to other insurance, reinsurance, indemnity or reimbursement which you have purchased to apply in excess of this policy.

H. Inspection:

We have the right, but are not obligated to, inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards.

I. Audit:

You will keep records needed to compute the premium in accordance with Part Six - Premium and send copies of those records to us when we ask for them. You will let us examine and audit all of your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for the storing and retrieving of data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium.

J. Assignment:

An assignment of interest under this policy will not bind us unless an endorsement assigning interest under this policy is issued by us to be part of the policy.

K. Bankruptcy or Insolvency of Insured:

Your bankruptcy or insolvency will not relieve us of our duties and liabilities under this policy. After your retention has been paid, payments due under this policy will be made by us as if you had not become bankrupt or insolvent, but not in excess of our limit of indemnity. Such payments will be made to the Trustee in Bankruptcy or as a Court of competent jurisdiction may ultimately direct.

L. Cancellation:

We or you may cancel this policy at any time by advance written notice stating when the cancellation is to take effect. Such cancellation notice shall be not less than the number of days shown in Item 4 of the Information Page.
If we cancel because of non-payment of premium, we have the right to cancel this policy on ten days written notice to you. Mailing notice of cancellation by registered or certified mail or delivery of such notice by personal service at the address shown in Item 2 of the Information Page will be sufficient to prove notice. If you cancel this policy on a date other than the end of the policy period, we will determine earned premium in accordance with the short rate table in use by us. You shall pay the earned premium determined for the cancelled policy. Any premium due you will be returned promptly to you. Actual return of premium due you is not a condition to the effectiveness of cancellation of this policy.

M. Sole Representative:

If more than one Insured is named in Item 1. of this policy, the Insured first named in Item 1 of the Information Page will act on behalf of all Insureds to give or receive notice of cancellation, receive return premium or indemnity, or request change in this policy.

N. Policy Conforms To Law:

If terms of this policy are in conflict with any law applicable to this policy, this statement amends this policy to conform to such law.

O. Captions:

The headings or captions used in this policy are for the purpose of reference only and shall not otherwise affect the meaning of this policy.

IN WITNESS WHEREOF, the Insurer has caused this policy to be signed by its President and secretary in Boston, Massachusetts, but this policy shall not be binding on the Insurer unless countersigned by another officer or attorney-in-fact of the Insurer.

Dexter R. Legg
Secretary

Edmund F Kelly
President

EXHIBIT 2

AFFIDAVIT OF GARY LOCKLEAR

I, **Gary Locklear**, being sworn, states:

1. I am competent to testify to the statements made herein.
2. I was an employee of FCS Industries, Inc. ("Company") from April 1, 1984 to May 31, 2009.
3. I held several titles over my course of employment with the Company, and when last employed I was a general manager.
4. On February 8th, 2008, I was working in Sterling Heights, Michigan in a rail yard where my job required me to load vehicles into rail cars for transport to various locations.
5. My duties included loading vehicles into rail cars, climbing ladders, lifting objects, walking between rail cars and over train tracks, as well as entering and exiting vehicles and rail cars.
6. There was an accumulation of ice and snow on the ground that day.
7. On February 8th, at approximately, 11:30 a.m., while I was loading cars, I slipped and fell due to slippery conditions caused by ice and snow. (See Exhibit 1)
8. I sought treatment at Concentra Medical Center. (See Exhibit 2)
9. I was diagnosed with contusions to several parts of my body, including, buttocks, truck, elbow, and hands. (See Exhibit 2)
10. On February 10th, 2008, while I was performing my job functions in a Sterling Heights rail yard, I again slipped and fell due to conditions caused by accumulation of ice and snow. (See Exhibit 1)
11. The fall of February 10th, 2008 aggravated the injuries I sustained just two days prior.
12. I felt pain throughout my shoulder, back, neck, and buttocks, although the low back caused me the greatest discomfort.

13. An MRI in May 2008 revealed spinal stenosis and disc herniation. (See Exhibit 3)
14. My doctors treated my low back injury conservatively for a period of time but relief from pain was minimal.
15. I began treating with Dr. Truumees, and after non-operative treatments failed to relieve my pain, Dr. Truumees recommended surgery. (See Exhibit 4)
16. On July 23, 2008, I underwent a lumbar laminectomy and discectomy. (See Exhibit 5)
17. After my lumbar surgery, I attended multiple sessions of physical therapy.
18. By September 2008, I was back at work with restrictions. My low back was feeling better after surgery, and physical therapy seemed to be helping with being able to complete daily activities, but I still had complaints of pain. (See Exhibit 6)
19. I began experiencing more neck pain as time went on, and I believe as my low back conditions were improving and I was reducing my pain medication intake, the real concerns with the condition of my neck were now becoming apparent.
20. By January 2009, my pain had increased so much that Dr. Grant increased my pain medication and injections, as well as ordered an additional MRI. (See Exhibit 7)
21. In March 2009, I was referred to Dr. Lucia Zamorano for treatment of my neck pain. (See Exhibit 8)
22. On April 27, 2009, I had an MRI of my cervical spine, which revealed several disc herniation. (See Exhibit 9)
23. In a separate MRI on April 27th, it was also determined that I had a full thickness rotator cuff tear. (See Exhibit 9)
24. I was prescribed a cervical bone stimulator in May 2009 to treat my cervical issues. (See Exhibit 10)

25. Surgery was ultimately recommended, and I proceeded with cervical surgery.

26. On June 1, 2009, I underwent cervical discectomy and fusion. (See Exhibit 11)

27. After my neck surgery, I was no longer able to perform my duties at work and was not able to return to work.

28. Post-cervical surgery, I began another round of physical therapy and continued physical therapy for an extended period of time. (See Exhibit 12)

29. In August 2010, I had another MRI of my lumbar spine, which revealed changes from previous MRIs. (See Exhibit 13)

30. In September 2010, I had rotator cuff repair surgery. (See Exhibit 14)

31. In November 2011, I underwent a lumbar fusion. (See Exhibit 15)

32. I continued treating with Dr. Zamarono through 2011.

33. My neck and back pain persisted, and I continued to treat with injections and physical therapy throughout 2012. (See Exhibit 16)

34. In 2013, I had an additional lumbar laminectomy. (See Exhibit 17)

35. In 2015, I moved to Tennessee where I have continually sought treatment for neck and back pain. I continue to take pain medication to relieve my symptoms.

36. In February 2021, I had additional cervical and lumbar spinal fusions.

37. It my belief that my neck, shoulder, and back injuries occurred in February 2008 when I slipped and fell at work.

38. I initially sought treatment for the most problematic condition, which at the time was my low back, and as time progressed, my neck injury was apparent and had to be treated.

39. I would not consider my neck injury and my back injury as separate incidents because throughout my time treating for my low back condition, I experienced severe neck pain to the point that surgical intervention was necessary.

40. My 2008 workplace injury forced me to leave the workforce long before I intended to, but the pain that I experienced and subsequent surgeries left me no choice.

/s/ Gary Locklear

Gary Locklear

PATSY B. EVANS STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF WAYNE

STATE OF TENNESSEE)

Wayne COUNTY)

Signed and sworn to before me in Wayne County, Tennessee on this the 19th day of August, 2021.

/s/ Patsy B Evans

Notary's Name: PATSY B EVANS

Notary public, State of Tennessee, County of TN.

My commission expires 10/23/2024.

Acting in the County of Wayne.

Exhibit 1

SUPERVISOR'S INVESTIGATION REPORT
MOTOR VEHICLE / PERSONAL INJURY

The unsafe acts of drivers and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and name them and to state the remedy for them in this report.

Company: MIS	Terminal / Division: AUTO HANDLING
Driver: GARY LOCKWOOD	Type of Vehicle / Identifying no.
Location of Accident (state,town,state): STERLING Hgts MI	Date & Time of Accident: 2-8-08 11:30 / 2-10-08 8:00

No. of Persons Injured and Extent of Property Damage (Company and other)
1 person no property damage

Description of Accident (State in detail what occurred just before, and at the time of accident)
ON 2-8-08 employee was putting units in yard when he slipped and fell down on ice between rows.

2-10-08 TO DETAIL RAILCAR NUMBER EMPLOYEE SLIPPED AND FELL DUE TO ICY CONDITIONS

Unsafe Condition (Describe unsafe conditions such as faulty brakes, lights, etc. contributing factors)
ON 2-8-08 SNOW and ICE

ON 2-10-08 SNOW AND ICE

Unsafe Act (Describe the unsafe action of driver as turning from wrong lane, speeding, etc.)
VASCOR FAILED TO MAINTAIN SAFE WORK AREA BY NOT REMOVING SNOW AND ICE PROPERLY

Remedy (As a supervisor, what action have you taken or do you propose to prevent an accident)
REPORT Accident to VASCOR & INSIGHT AND HAVE ASK NUMEROUS TIMES TO HAVE ICE SIDED REMOVED. REQUESTED MORE SALT BETWEEN TRACKS

Supervisor signature	Reviewed and Approved by	Date Report Processed
2/11/08		

See reverse side for specks and additional detail - Attach pictures to original form

Exhibit 2

Concentra Medical Center
33089 Groesbeck Rd Fraser, MI 48026
Phone: (586) 296-2800 Fax: (586) 296-6190

Case Date: 02/08/2008

Physician Activity Status Report

Patient: Locklear, Gary M.
SSN: 371-52-4131
Address: 12266 Silver Lake
BRIGHTON, MI 48116
Home: (248) 486-0684
Work: (586) 634-5457 Ext.:

Employer Location: TVM/TV Minority
Address: 9850 Pelham Rd
TAYLOR, MI 48180
Auth. by: J McFarlin

Contact: Safety (Tabitha, Hazel, Gina)
Role:
Phone: (800) 325-7884 Ext.: 2162
Fax: (313) 295-7461

This Visit: Time In: 09:23 am Time Out: 11:58 am Recordable: N/A Visit Type: New

Treating Provider: Thomas Lamacchia, PA-C

Diagnosis: 922.32 Contusion of the Buttocks
922.9 Contusion of Trunk
923.11 Contusion of Elbow
923.20 Contusion of Hand(s)

Medications:
- [x] Dispensed Prescription Medication to Patient
- [ ] Dispensed Over-The-Counter Prescription
- [ ] Written Prescription given to Patient

Patient Status:

No Activity - Returning for follow-up visit

Remarks: The office manager (J McFarlin) voided the BAT and UDS for this treatment.

Employer Notice: The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 02/24/2008 Actual Date of Maximum Medical Improvement:

Next Visit(s): Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Visit Date: Tuesday February 12, 2008 11:00 am
Provider/Facility: Thomas Lamacchia, PA-C

Concentra.

Transcription

33089 Groesbeck Rd Fraser, MI 48026 (586) 296-2800

Patient:	Locklear, Gary M	**Service Date:**	02/10/2008
Soc. Sec. #	371-52-4131	**Injury Date:**	02/08/2008
Date of Birth:	12/12/1950 **Age:** 57	**Employer:**	TVM/TV Minority
Service Location:	CMC - Det Fraser		9850 Pelham Rd
Service ID #:	226014428		
Claim #:			TAYLOR, MI 48180
Dictator:	Ronald E Lambert,PA-C		
Diagnosis:	922.32 Contusion of the Buttocks		

Notes: CHIEF COMPLAINT:
Patient is a 57 year old male general Manager employee of TVM/TV Minority who complains about his back which was injured on 02/08/2008 11:30:00 AM.

PATIENT STATEMENT:
Patient states :"While at work in yard and between tracks, I slipped on ice when I fell and injured my right side with lower back."
TODAYS VISIT IS A NEW INJURY.

HISTORY OF PRESENT ILLNESS:
See medical assistant above except the following: Patient fell hitting Rt Hip,Rt Low back Rt elbow left hand/Thumb. Pain began abruptley. Gradually became progressively worse. The pain is located on right lumbar region and Rt Hip .Rt elbow ,left hand/thumb.. The pain is described as moderate, Throbbing ache., nagging, persistent, pressure, worse when bending forward and back to the erect position., Prolonged walking & standing. And Lifting carrying gripping.. Pain Intensity Level: 6/10. The pain did not radiate. The symptoms are exacerbated by Prolonged standing,bending.,squatting,kneeling,pushing,pulling arms overhead and pressure., pushing, pulling or carrying. The symptoms are alleviated by resting, Changing positions. Or ice.
No prior history of Injury to affected areas, No past hospitalizations. Injury history reviewed. Past surgical history reviewed. Appendectomy age 20.

SOCIAL HISTORY: Smokes 10 cigarettes/day. Has been a smoker for 30 years. Denies alcohol use.

FAMILY HISTORY: Noncontributory based upon review of comprehensive questionnaire.

PAST MEDICAL HISTORY: Patient has hyperlipidemia..

Current Medications:
- Lipitor 20 mg PO daily

Allergies: Denies known medication allergies.
Immunizations: Up to date.

ROS: The 12 system ROS form provided to the patient has been reviewed and all are negative. Except present complaint noted in H.P.I.

PE:
APPEARANCE: Alert. Awake. Healthy. In no acute distress. Well-developed. Well-hydrated. Well-nourished. In moderate discomfort.
VITAL SIGNS: See MA notes.
HEENT: Atraumatic, normocephalic. No pharyngeal erythema or exudate. No stridor.

CHEST: Breath sounds clear bilaterally. No rales. No wheezes. No rhonchi. Good air movement.
CARDIOVASCULAR: Regualr rate and rhythm. Nl S1/S2. No S3/S4. No murmurs, gallops, rubs or clicks.
ABDOMEN: Soft. No tenderness. No abdominal distention. No hepatomegaly. No abdominal masses. No pulsatile mass. No palpable aortic enlargement. Bowel sounds normal. No organomegaly.

Dictated But Not Read

Dictated By: Ronald E Lambert,PA-C

Dictated On: Feb 10 2008 12:15PM

Concentra.

Transcription

33089 Groesbeck Rd Fraser, MI 48026 (586) 296-2800

Patient:	Locklear, Gary M	**Service Date:**	02/10/2008
Soc. Sec. #	371-52-4131	**Injury Date:**	02/08/2008
Date of Birth:	12/12/1950 **Age:** 57	**Employer:**	TVM/TV Minority
Service Location:	CMC - Det Fraser		9850 Pelham Rd
Service ID #:	226014428		
Claim #:			TAYLOR, MI 48180
Dictator:	Ronald E Lambert,PA-C		
Diagnosis:	922.32 Contusion of the Buttocks		

Notes: MUSCULOSKELETAL:
Lumbar: C/O Lumbar,low back discomfort,lumbar paravertebral muscles.No symptoms of cauda equina syndrome.No saddle anesthesia .No bowel or bladder problems. No foot drop.No E.H.L. or E.D.L. weakness.SLR negative 85 degrees bilaterally.No C.V.A. tenderness. Heel walks toe walks without discomfort.Neg distal circulatory deficits.Neg lower extremity hypesthesias or dysesthesia.Negative pin prick ,light touch vibratory or proprocetive deficits noted.no palpable spasm,normal gait.reflexes symmetric, Knee jerk 2 Plus Ankle jerk 1 plus.Reflexes symmetric.Normal gait.Negative babinski,neg waddle signs,negatve F.A.B.E.R.E sign,Negative laseques sign,negative gaenslens sign,negatve patricks sign.Motor strength 5/5 all major flexors and extensors all 4 extremities. Positive tenderness rt lumbar paravertebral muscles with anteflexion to 45 degrees and has pain with rt lateral flexion and rotation past 10-15 degrees. Distal pulses intact cap refill time less than 2 seconds. Negative distal pin prick lightouch proprioceptive or vibratory deficits noted. The remainder of the back examination was unremarkable.
Right Hip: Tenderness over the greater trochanter and over the hip joint. Normal conformation . No swelling.rubor or ecchymosis. Mild antalgia. Cannot squat, Positive tenderness with F.A.B.E.R.E. maneuver. Positive patricks sign. Foot sensation intact. Normal dorsalis pedis pulse. Normal femoral pulse. Negative distal neurosensory vascular deficits.Negative distal pinpriclk light touch or 2 point discrimination deficits, C.F.T Immediate. Ecchymosis with mild soft tissue swlling noted on exam. Normal gait. Femoral ,popliteal.dorsalis pedis and posterior tibialis pulses normal. The remainder of the hip examination was unremarkable.
Right Elbow: Pt has ecchymosis and soft tissue swelling Tender at olecranon triceps insertion. No radial head tenderness. Mild swelling & tenderness over lateral epicondyle. Tenderness with supination and pronation radial humeral joint. Pain on movement both in flexion and extension but mostly with full extension. Capillarry refill time immediate. Radial pulse is 2+. Negative distal piprick or light touch distally. Sensation over the distribution of the radial nerve intact. Sensation over the distribution of the median nerve intact. Sensation over the distribution of the ulnar intact. Normal light touch sensation of the Distally.. Normal 2-point discrimination of the Distally.. Sensation over the hand intact. The remainder of the elbow examination was unremarkable.
Left Hand: Normal confirmation no obliteration of bony landmarks. Hand shows no deformity. No ecchymosis. No effusion. No joint laxity appreciated. C/o tenderness. C/o tenderness thenar emminence. 1st M.C.P.J. thumb. Tender with thumb to little finger opposition & thumb flexion into palm. NEGATIVE PHALENS, NEGATIVE TINELS,.NEGATIVE FINKLESTEINS,NEGATIVE SNUFFBOX NEGATIVE HAMBYS SIGN.NEGATIVE FLICK. No swelling. C/o decreased grip strength. Pulses intact. Capillary refill time immediate the remainder of the hand examination was unremarkable.

X-RAY / LAB REPORT:
Lumbar series:
LS-spine x-ray:
All films reviewed in office, patient advised readings are preliminary and films will be sent to radiologist for final report.

Hip X-Ray: Rt patient advised that the x-ray reading was preliminary and will be reviewed by an outside radiologist. Await radiologist final report. 3 View Rt Elbow. Possible chip hx vs DJD Rt Rlbow Await radiologist report. 3 view left hand xrays appear negative pending radiologist report.

ASSESSMENT:

Dictated But Not Read

Dictated By: Ronald E Lambert,PA-C

Dictated On: Feb 10 2008 12:15PM

Concentra.

Transcription

33089 Groesbeck Rd Fraser, MI 48026 (586) 296-2800

Patient:	Locklear, Gary M	**Service Date:**	02/10/2008
Soc. Sec. #	371-52-4131	**Injury Date:**	02/08/2008
Date of Birth:	12/12/1950 **Age:** 57	**Employer:**	TVM/TV Minority
Service Location:	CMC - Det Fraser		9850 Pelham Rd
Service ID #:	226014428		
Claim #:			TAYLOR, MI 48180
Dictator:	Ronald E Lambert,PA-C		
Diagnosis:	922.32 Contusion of the Buttocks		

Notes:
1. Back/buttock contusion. 922.3.
2. Hip contusion. 924.01.
3. Elbow contusion. 923.11.Rt
4. Hand contusion. 923.20.Lt.
5. Contusion thumb. 923.3.Lt

PLAN:

MEDICATIONS:
Ibuprofen 600 M.G.M.Take 1 tab three times daily with meals.Denies peptic ulcer disease.G.E.R.I
,kidney disease or asthma,Pt advise not to take this medicine with other Nonsteroidal,antiinfl
drugs., Cyclobenzaprine 10 mgm.Take half a tab at bedtime.PT CAUTIONED THAT MEDICINE
MAY CAUSE DROWSINESS NO DRIVING OR OPERATING MACHINERY, and All medicines were dispensed
or administered in clinic except those prescriptions were written for.
- Pt advised to ice affected area approximately 20 min 3 times per day.

Start physical therapy ,eval and treat 2-3 times per week for 1-2 weeks.

DURABLE GOODS: Thumb spica splint.Left hand.off at bedtime.
- Sling rt Arm .

ACTIVITY STATUS:
No activity. The provider took the patient off work.

RETURN FOR EVALUATION: Tuesday

Return sooner if symptoms recur, worsen, new symptoms develop, any increase in pain
or any signs of infection.

*** The anticipated time for MMI is 10-14 days.***
(This injury may be OSHA recordable)
* The patient was advised that the x-ray reading was preliminary and will be reviewed
by an outside radiologist for final report.

- Medication instructions, work status, diagnosis and treatment plan clearly explained
and discussed with patient by myself. The patient was given opportunity to ask questions
concerning the diagnosis amd treatment plan. The patient acknowledged understanding
of the diagnosis and treatment.
The employees company was contacted today. Left voice message with. Mr. Jack Mc
Farlin CONCERNING NO WORK Status.
Thank you for visiting Concentra for occupational care and for the opportunity to
participate in the care of this patient.

Vital Signs: BP: 129/79. P: 74. R: 16. T: 98.2 degrees F orally. The patient
weighs 225 lbs (102.3 kgs). The patients height is 6 ft. 1 in. (185.4 cm)

Current Medications: Lipitor
Allergies: No known allergies

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Dictator:	Ronald E Lambert,PA-C		
Diagnosis:	922.32 Contusion of the Buttocks		

Notes:
Time:10:29 AM by: M G.

Dictated But Not Read

Dictated By: Ronald E Lambert,PA-C

Dictated On: Feb 10 2008 12:15PM

Concentra.

Transcription

33089 Groesbeck Rd Fraser, MI 48026 (586) 296-2800

Patient:	Locklear, Gary M	**Service Date:**	02/12/2008
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Date of Birth:	12/12/1950 **Age:** 57	**Employer:**	TVM/TV Minority
Service Location:	CMC - Det Fraser		9850 Pelham Rd
Service ID #:	226017387		
Claim #:			TAYLOR, MI 48180
Dictator:	William Seyler, PT		
Diagnosis:	922.32 Contusion of the Buttocks		

Notes:

VISIT HISTORY

INITIAL VISIT INFORMATION:
Patient is a 57 year old male employee of TVM/TV Minority who reports that his back was injured on 2/8/2008 11:30:00 AM.

PATIENT STATEMENT:
Patient states :'While at work in yard and between tracks, I slipped on ice when I fell and injured my right side with lower back.'

Visit Number (cumulative total): 1 visits.
Missed Appointments (for this case): 0 visits.

SUBJECTIVE

THERAPY INITIAL EVALUATION
Patient is referred for therapy with medical diagnosis of left wrist sprain, right elbow contusion, right shoulder contusion, lumbar strain and right hip contusion
Mechanism of Injury: Patient reports that he fell onto her right side on Friday. He reports that on Sunday he fell again onto his right side.
Job Title: manager
Essential Job Functions: walking, driving
Chief Complaint: intermittent lumbar pain, left thumb pain, right elbow pain, right shoudler pain
Exacerbating Factors: prolonged positions increase lumbar pain, gripping, lifting increase the right elbow pain, shoulder pain is increased by elevating the shoulder, left thumb pain is increased with opposition
Alleviating Factors: none
Pre-Injury Status: Patient working at regular duty status prior to injury with no history of injuries or impairments to the affected area.
Medical History: Non-Contributory, refer to medical record.
Radiology: X-rays negative per medical provider.

OBJECTIVE

Posture: increased lumbar lordosis
Transitional Movements/Function: Fluid without guarding
Gait: No deviations noted
Integumentary System Integrity: Bruising present in posterior right elbow
Sensation: Grossly intact to light touch in C5-T1 dermatomes
Palpation: Tenderness to palpation at posterior right elbow
Hand Dominance: Right hand dominant

CERVICAL ROM

Flexion Loss:	No Loss
Extension Loss:	mod Loss
Right Rotation Loss:	No Loss

Dictated But Not Read

Dictated By: William Seyler, PT

Dictated On: Feb 12 2008 1:13PM

Concentra.

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Notes: Left Rotation Loss: No Loss
Right Side Bending Loss: No Loss
Left Side Bending Loss: No Loss

SHOULDER ACTIVE RANGE OF MOTION
Right:
Flexion: 100?
Extension: 20?
Abduction: 90?
Internal Rotation: 50?
External Rotation: 60?

SHOULDER MANUAL MUSCLE TEST
Right:
Shoulder Flexion: 4+/5
Shoulder Abduction: 4+/5
Shoulder Internal Rotation: 4+/5
Shoulder External Rotation: 4+/5

Elbow Examination: (WNL= within normal limits)

AROM Left, Right:
Flexion: 0-130, 0-130 with pain
Extension: 0, 0 with pain ++
Supination: 0-80, 0-80
Pronation: 0-80, 0-80

Manual Muscle Testing in Neutral Left, Right:
Flexion: 5/5, 5/5
Extension: 5/5, 5/5
Supination: 5/5, 5/5
Pronation: 5/5, 5/5
Wrist Flexion: 5/5, 5/5
Wrist Extension: 5/5, 5/5

Grip Strength: Left: 60 lbs Right: 75 lbs

Special Tests Left, Right:
Tennis Elbow Test: WNL, WNL
Golfers Elbow Test: WNL, WNL
Varus Stress: WNL, WNL
Valgus Stress: WNL, WNL

Wrist/Forearm Examination: (WNL= within normal limits)

AROM Left, Right:
Flexion: 0-80, 0-80
Extension: 0-70, 0-70
Radial Deviation: 0-15, 0-15
Ulnar Deviation: 0-30, 0-30

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Notes:

Supination: 0-80, 0-80
Pronation: 0-80, 0-80
CMC Flexion: linear to index, linear to index CMC
Extension: 0-50 with pain, 0-50
CMC Abduction: 0-50 with pain, 0-50
CMC Adduction: linear to index, linear to index
CMC Opposition: 1 to 5 Tip with pain, 1 to 5 Tip

Manual Muscle Testing in Neutral Left, Right:
Flexion: 5/5, 5/5
Extension: 5/5, 5/5
Radial Deviation: 5/5, 5/5
Ulnar Deviation: 5/5, 5/5
Supination: 5/5, 5/5
Pronation: 5/5, 5/5
CMC Extension: 5/5 with pain, 5/5
CMC Abduction: 5/5 with pain, 5/5

Tip Pinch: Left: 16 lbs Right: 16 lbs

Special Tests Left, Right:
Finkelstein Test: painful at midcarpal joint, WNL

LUMBAR ROM:

Flexion: Min loss with pain ++
Extension: min-mod loss with pain
Side bend right: No loss
Side bend left: No loss
Rotation left: No loss
Rotation right: No loss

TESTING FOR EXTENSION ROTATION SYNDROME

Standing
Paravertebral muscular asymmetry: -
Hyperlordotic or hinge point present: +
Pain with return from flexion in standing: +

Supine:
Pain with legs in extension: +

Sidelying:
Pillows between knees decreases symptoms: +

ASSESSMENT

The patient examination is consistent with the medical diagnosis. Pt presents with a left scaphoid-trapezium dysfunction, right elbow contusion, lumbar extension rotation syndrome and shoulder derangement
Impairment List:

Dictated But Not Read

Dictated By: William Seyler, PT

Dictated On: Feb 12 2008 1:13PM

Concentra.

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Notes: AROM
Pain
Muscle Performance
Joint Mobility

Impairments above correlate with the following preferred practice pattern(s)
Localized Inflammation
Ligament Connective Tissue
Muscle Performance
Spinal Disorders

These impairments prevent the patient from performing their standard activities of daily living and work activities. Therapy is indicated to address these deficits and the patient demonstrates good prognosis for improvement. The plan of care was discussed with the patient, who voiced understanding and agreed to proceed.

Goals:

Therapy goals to be achieved within 6 visit(s)
- Patient will return to work, same job same employer
- Patient will demonstrate independence and be compliant with home exercise program
- Patient will demonstrate proper body mechanics with job functions and/or associated activities of daily living
- Functional: Pt able to drive car for 30 min without pain
- Grip Strength: Increase Grip Strength to 75 pounds
- Range of Motion: Increase range of motion to the following: shoulder flexion to 160?

PLAN

Frequency and Duration: daily times 3 then 3 times a week for 1 week.
Treatment will include: Ther-ex, Neuro re-ed, Functional Act, Manual techniques, and supplies/modalities as needed.
Therapeutic exercises such as shoulder extension to improve loss of shoulder range of motion.
Therapeutic activities such as lifting, carrying, pushing and pulling to restore patient to prior functional level.

TREATMENT

97001 - PT Eval - same day as MD visit, Qty: 1
PT Evaluation same day as MD visit
97110 - Therapeutic Exercises-15m, Qty: 2, Minutes: 25
Therapeutic Exercises .
97140 - Manual Therapy-15m, Qty: 1, Minutes: 10
Manual Therapy .

Therapeutic Exercise (One to One)

Thumb abd with compression, 15 reps (Clinic and HEP)

Dictated But Not Read

Dictated By: William Seyler, PT

Dictated On: Feb 12 2008 1:13PM

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Notes: Thumb opp with compression, 15 reps
wrist extension stretch, 10Seconds X 2Sets, Verbal Cues (Clinic and HEP)
repeated extension, 15 reps (Clinic and HEP)
hooklye rotation, 20 X 3, Supine
pelvic tilt, 25Reps, Supine (Clinic and HEP)

Manual Therapy

Wrist:
P-A glide trapezi on scaphoid, 20 reps

Precautions-Comments:

Cumulative Therapy Charges:

Qty - Description
001 - Manual Therapy-15m

002 - Therapeutic Exercises-15m

001 - PT Eval - same day as MD visit

Dictated But Not Read

Dictated By: William Seyler, PT

Dictated On: Feb 12 2008 1:13PM

Exhibit 3

Great Lakes MRI of Michigan

MRI Interpretations provided by the Cleveland Clinic Department of Radiology

41371524131
LOCKLEAR, GARY
DOB: 12-Dec-1950 Sex: M

Radiology Report

17634501 21-May-2008 11:05 AM Requested by: Albert Belfie, D.O.
MR LUMBAR SPINE WITHOUT CONT

History:
SLIPPED AND FELL ON ICE ABOUT 45 DAYS AGO. BACK AND LT LEG PAIN. NUMBNESS TO LT FOOT. WEAKNESS TO LT LEG.

Routine noncontrast lumbar spine MRI was performed.

Vertebral bodies are normal in height. There is disc desiccation of varying degrees throughout the lumbar spine. There is mild disc space narrowing L4-5 and moderate narrowing at L5-S1. There is a slight anterolisthesis of L4 on L5 and a slight retrolisthesis of L5 on S1. The conus medullaris has a normal appearance and terminates at approximately T12.

T12-L1 and L1-2: Unremarkable.

L2-3: There is mild facet and ligamentum flavum hypertrophy without significant central canal or foraminal stenosis.

L3-4: There is a disc bulge asymmetric to the left. It demonstrates an annular tear. There is moderate facet and ligamentum flavum hypertrophy. The central canal is borderline in size. There is mild to moderate left foraminal stenosis. The right neural foramen is patent.

L4-5: There is mild to moderate central canal stenosis secondary to an annular disc bulge, facet and ligamentum flavum hypertrophy. A 4 mm synovial cyst is suspected to arise from the left facet joint. There is moderately severe biforaminal stenosis.

L5-S1: There is a disc bulge with a superimposed moderate left subarticular disc protrusion. It compresses the left descending S1 nerve root. There is endplate osteophytosis, moderate facet and ligamentum hypertrophy. The central canal is borderline in size. There is severe left and moderate severe right foraminal stenosis.

Prevertebral/paraspinal soft tissues are unremarkable.

(586)427-7226 · Toll Free (866)755-SCAN · Fax (586) 427-4966
27301 Schoenherr, Suite 100, Warren, MI 48088

Great Lakes MRI of Michigan
MRI Interpretations provided by the Cleveland Clinic Department of Radiology

41371524131
LOCKLEAR, GARY
DOB: 12-Dec-1950 Sex: M

Radiology Report

17634501 21-May-2008 11:05 AM Requested by: Albert Belfie, D.O.
MR LUMBAR SPINE WITHOUT CONT

Impression:

1. At L3-4, there is mild to moderate left foraminal stenosis.

2. At L4-5, there is mild to moderate central canal and moderately severe biforaminal stenosis.

3. At L5-S1, there is a left subarticular disc protrusion compressing the left descending S1 nerve root. In addition, there is severe left and moderate severe right foraminal stenosis.

Reported by: Alfonso Rivera, MD /signed by/ RIVERA, ALFONSO, MD

Transcribed on: 22-May-2008 8:39 AM by Commissure Interface
Finalized on: 22-May-2008 8:39 AM by Commissure Interface

THANK YOU FOR REFERRING YOUR PATIENT TO GREAT LAKES MRI.
SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS REPORT PLEASE FEEL FREE TO CONTACT OUR OFFICE AT (586)427-7226.

(586)427-7226 · Toll Free (866)755-SCAN · Fax (586) 427-4966
27301 Schoenherr, Suite 100, Warren, MI 48088

Exhibit 4

Locklear, Gary
12/12/1950
Truumees, Eeric
06/05/2008
Dictation

TO: Independent Claims Services

CHIEF COMPLAINT:

1) Back and leg pain.

HISTORY: Mr. Locklear presents complaining of pain in his back going down his left leg. He reports the onset of symptoms after a slip and fall in February. He denies major previous back problems. The pain has become increasingly severe and he rates it now as 10/10. He describes it as cramping, aching and shooting. He has at least some constant pain and feels markedly functionally limited because of it. He has had difficulty walking or straightening his leg.

Previous treatments have included physical therapy and chiropractic. He has not yet had injection therapies. He has tried a number of different medications including Lyrica, Flexeril, Vicodin, OxyContin and Celebrex.

At this point he is taking Oxycodone 10, 4 per day. He is on Lyrica 150 mg. and Celebrex 200 mg.

Past medical history is essentially negative. He does take Omeprazole and Lipitor. He denies major cardiopulmonary problems however. He denies a history of neurologic issues or cancer.

Surgical history is limited to two operations in the 70?s including an appendectomy and Hemorrhoidectomy. He has no known drug allergies.

Family history is significant for diabetes and neurologic issues, but not major spondylosis.

Review of systems is significant for a sense of weakness about his leg, as well as trouble standing. He has had bowel and bladder difficulties. He has had positional night pain, but no fevers, chills or other systemic complaints.

Social history reveals that he continues to work, but is having difficulty with this. He is a general manager and has been for 5-years. He is a ¾-pack/day smoker times 20-years.

PHYSICAL EXAMINATION: On exam today, Mr. Locklear is a 6? 2? tall, 225 pound male. He is in moderate distress due to pain. He has difficulty sitting. He stands in a knee-flexed posture. His gait is antalgic as well. He has no broad based gait nor ataxia. He has marked limitation of thoracolumbosacral motion. He has pain mediated weakness in the left leg and has a difficult exam as a result. His reflexes are 0-1+ and symmetrical. His vascular exam is intact.

(CONTINUED)

X-RAY EXAMINATION: X-rays are available for my review including AP and lateral views of the lumbar spine. These demonstrate small T12 ribs for 6 total lumbar segments. Bony mineralization appears adequate. He has an anterolisthesis of L4 on L5 and marked disc height loss of L5 on S1. He has congenitally short appearing pedicles particularly in the low lumbar spine. There is very little motion on F&E. There is no evident abnormal motion. There is no clear change in the spondylolisthesis, but little overall motion is noted.

I reviewed an MRI with Mr. Locklear. This is dated 05-21-08 and was performed at Great Lakes MRI. These demonstrate a synovial cyst on the left side at L4-5 in association with at least moderate stenosis. He has fairly severe entrance zone stenosis in the foraminae. At the L5-S1 level, he has a left sided disc herniation with compression on the S1 root. He has borderline central canal perhaps due to the congenital stenosis.

ASSESSMENT:

1) L4-5 stenosis with left synovial cyst.
2) L5-S1 disc herniation to the left.
3) Intractable back and left leg pain.

PLAN: I had a long discussion with Mr. Locklear today regarding further evaluation and treatment options for his pain. His pain has become increasingly severe over 4-months now. On the other hand, he denies previous problems. Given the two level disease he has and the limitations of his exam today due to the severity of his pain, I am suggesting epidural steroid. This may be diagnostically and therapeutically helpful for him. Certainly if this fails to give him adequate relief of his symptoms, he would be a good candidate for decompression. At that time, further attempts to localize his symptomatology between S1 and L5 may be useful relative to the need for discectomy alone versus treatment of the spondylolisthesis.

I have gone over the risks, benefits and alternatives of various approaches with Mr. Locklear in detail. I went over the natural history of radiculopathy. I have asked him to return to see me in 4-6 weeks. Due to the severity of his pain, I attempted to get him in with Dr. Schechet tomorrow. Unfortunately, Mr. Locklear has a court appearance and is unable to have the injection. We will get it scheduled as soon as we can. Based on the severity of his symptomatology, I suggested if he has any worsening, he should present to the ER and more aggressive management could be undertaken there.

Eeric Truumees, M.D.
ET/kc

Dictated but not read.

Electronically signed on 06/17/2008 by Truumees, Eeric

Locklear, Gary
12/12/1950
Truumees, Eeric
07/08/2008
Dictation

TO: Independent Claims Service

CHIEF COMPLAINT:
1) Follow up back and leg pain.

HISTORY: Mr. Locklear returns today in follow up, having first been seen on 06-05-08. At that time, based on the severity of back and leg pain, we recommended epidural steroid injections for spinal stenosis and a disc herniation.

Mr. Locklear had a single injection. He had significant spasms and pain and has not been able to go through further injections. The injection he had did not give him much in the way of relief of his symptoms which if anything have worsened over time. He has had no new weakness however. He rates his pain as 9/10. He states he is continuing to work at least on a part-time basis. There have been no bowel or bladder changes, or other interval changes in his review of systems.

PHYSICAL EXAMINATION: Mr. Locklear is in moderate distress due to pain. He is unable to sit for any period of time and stands and paces. That said, he has ongoing tension signs, but no new weakness. There is no wasting. His gait, while appearing somewhat antalgic, is not ataxic

X-RAY EXAMINATION: No new x-rays were done today.

ASSESSMENT:
1) Spinal stenosis and spondylolisthesis, L4-5.
2) L5-S1 disc herniation.
3) Ongoing radiculopathy.

PLAN: I discussed Mr. Locklear?s options with him. He continues to take pain medication essentially around the clock. The injection gave him no real relief of his symptoms and was difficult for him to get. With this in mind, he would be a good candidate for decompression. He has an L4-5 spondylolisthesis which could theoretically be considered for fusion or stabilization, but in the current context, a simple decompression may be adequate for him. I went over the pros and cons of these options in detail. Mr. Locklear does not feel he is ready for surgery at this point. He would like to try another pain management service. I gave him a referral to the Beaumont system and asked him to return in a month for recheck. I asked him to call or come in sooner if he has interval questions or problems, in particular, if he has increasing weakness. In this context, I do not feel comfortable keeping him on narcotic pain medications. I have asked him to discuss those with his primary physician. I have invited him to call or come in sooner if he has interval questions or problems.

Eeric Truumees, M.D.
ET/kc

Dictated but not read.

Electronically signed on 07/19/2008 by Truumees, Eeric

Exhibit 5

23 Jul

EERIC TRUUMEES M.D.
27207 LASHER, #200-B
SOUTHFIELD MI 48034
FAX: (248) 355-4960

REPORT

PROCEDURE DATE: 07/23/2008

SURGEON: Eeric Truumees, MD
ASSISTANT: Carrie Dehoff, MD
ANESTHESIA: General endotracheal

PREOPERATIVE DIAGNOSIS:
1. L4-5 stenosis.
2. L5-S1 disk herniation, left.
3. Intractable left leg pain.
4. Failure of medical management.

POSTOPERATIVE DIAGNOSIS:
1. L4-5 stenosis.
2. L5-S1 disk herniation, left.
3. Intractable left leg pain.
4. Failure of medical management.

OPERATION:
1. Laminotomy with lateral recess and foraminal decompression L4-5.
2. Laminotomy with lateral recess decompression of L5-S1.
3. Diskectomy L5-S1, left.

ESTIMATED BLOOD LOSS: 50 cc

COMPLICATIONS: None.

DRAINS: None.

OPERATIVE INDICATIONS: The patient is a 57-year-old male who is known to me from office evaluation. He has a history of predominantly left leg pain. He has undergone extensive non-operative management, which unfortunately has failed to improve his symptoms. His symptoms were most

Physician Signature
Eeric Truumees M.D.

Typed By | Date | Name of Report
D:07/23/08 1321 | Complete
T:07/24/08 0940 | RO Operative Report
T:

23 Jul

consistent with L5 radiculopathy. He has findings both at L4-5 at the traversing root level and at L5-S1 at the exiting root level. Based on the failure of non-operative management to improve his symptoms operative intervention was offered. We discussed various types of surgery including decompression alone, versus decompression and fusion. The patient wished to avoid fusion at all costs, but he recognized that if instability worsened after surgery revision surgery with instrumentation and fusion could become necessary. He understood there were no guarantees for surgical success. After a lengthy discussion of the risks, benefits and alternatives of the procedure the patient signaled his understanding of the entire procedure by the intelligent questions he asked. He elected to proceed.

OPERATIVE PROCEDURE: The patient was identified in the preoperative hold area. We reviewed the intended procedure, his findings and radiographic studies. All questions were answered. Preoperative antibiotics were administered. He was then taken to the operating room where general endotracheal anesthesia was administered by the anesthesia department. Once adequate anesthesia was obtained he was turned to the prone position on the Jackson frame. All bony prominences were carefully padded. His back was prepped and draped in the usual sterile fashion. Lateral fluoroscopy was used to confirm level localization and a 3 cm incision was made. This was deepened to the level of the fascia and the fascia was incised in the midline. A careful subperiosteal dissection of the left side lamina at L4, L5 and S1 was undertaken. We then placed a deep retractor. A marker was placed under the lamina at L5 and a lateral fluoroscopic image was obtained to confirm level localization.

Next we thinned the laminae with a Leksell rongeur. We used a curet to elevate the ligamentum flavum. A Kerrison was used to provide a midline decompression and laminotomy in a port hole manner. This was done after careful exploration for adhesions with a Woodson. There was a synovial cyst encountered at the L4-5 level as well as mild hypermobility of both L4-5 and L5-S1. Gross instability, however, was not noted. We next proceeded laterally. An undercutting technique was used where possible. Of note, the patient has quite tall spinous processes and the under cutting was somewhat limited in this regard and a more direct decompression was partly required.

Next we identified the nerve roots. These were gradually medialized. At the L4-5 level the disk was found to be largely intact. There was no free disk material or anterior ??????? compressive pathology. At L5-S1 and extruded disk herniation was noted and this was removed in 3-4 small

Physician Signature
Eeric Truumees M.D.

Typed By | Date | Name of Report
D:07/23/08 1321 | Complete
T:07/24/08 0940 | RO Operative Report
T:

pieces. This space itself was explored and very little remaining disk material was noted. There were no further free disk fragments.

A probe was then used to pass into the foramen at each level. We did use a foraminal Kerrison to provide additional decompression of the lateral recess and foramen at least to the mid zone. At the conclusion of the procedure the nerve roots were freely mobilizable. A return of CSF pulsation was noted. There was some epidural oozing but this was found to be well controlled with thrombin-soaked Gelfoam, which was removed prior to closure. Of note, the L5 and to a lesser degree the S1 nerve roots on the left side were found to be quite edematous and inflamed. The wound was then copiously irrigated. It was closed using #1 Vicryl in interrupted figure-of-eight fashion pn the fascia followed by 2-0 Vicryl in the skin and skin staples. A sterile bulky post surgical dressing was then applied and the patient was taken to the recovery room in stable condition. There were no complications.

Physician Signature
Eric Truumees M.D.

Typed By

Date
D:07/23/08 1321
T:07/24/08 0940
T:

Name of Report Complete
RO Operative Report

Exhibit 6

dictation Eeric Truumees - 09/16/2008

LOCKLEAR, GARY

12/12/1950

Truumees, Eeric

09/16/2008

dictation

To: Independent Claims Service

RECHECK

CHIEF COMPLAINT: Follow-up laminectomy.

HISTORY: Mr. Locklear returns today in 8 week follow-up from his surgery. He has been doing extremely well. His leg symptoms remain entirely resolved. He has belt-line low back pain as well as morning stiffness. He has gone back to work and has some end day endurance issues felt mainly in the low back. He has had no fever, chills or interval systemic complaints.

EXAMINATION: On examination today Mr. Locklear is in no apparent distress. His gait and coronal and sagittal spinal contour are intact today. He has a normal single toe rise. His wounds are well healed. He demonstrates a 66% of normal arc of thoracolumbar sacral motion. He has mild extensor weakness.

There is no pain on straight leg raise. His strength distally is 5/5. The remainder of his interval exam is unchanged.

IMAGING STUDIES: X-rays were reviewed including AP and lateral views of the thoracolumbar spine. These demonstrate his laminotomies without evidence of collapse or stress fracturing. He is straight on both the AP and lateral views with a restoration of normal Lordosis. There is no evidence of progression of his mild L4-5 spondylolisthesis.

ASSESSMENT:

1. Doing well after laminectomy.
2. Ongoing muscular pain.

dictation Eeric Truumees - 09/16/2008

PLAN: At this point, Mr. Locklear is doing extremely well after his surgery. I have recommended that we gradually lift his bending, lifting and twisting restrictions. I have recommended a course of physical therapy for him. I would like to see him back after the therapy for a recheck. I have invited him to call or to come in sooner if he has interval questions or problems.

EERIC TRUUMEES, M.D.

ET/rad

Dictated but not read

Electronically signed on 09/22/2008 by Truumees, Eeric MD

KYLE ANDERSON, M.D.
JEFFREY E. BALAZSY, M.D.
DAVID J. COLLON, M.D.
THOMAS J. DITKOFF, M.D.
PETER R. DONALDSON, M.D.
JEFFREY S. FISCHGRUND, M.D.
HARRY N. HERKOWITZ, M.D.
LAWRENCE T. KURZ, M.D.
JERRY A. MATLEN, M.D.

WEISSMAN, GITLIN, HERKOWITZ, M.D., P.C.
ORTHOPAEDIC SURGERY
&
PHYSICAL MEDICINE

27207 LAHSER, SUITE 200-B
SOUTHFIELD, MICHIGAN 48034
Tel. (248) 603-1900 Fax (248) 603-1901

6600 ORCHARD LAKE ROAD, SUITE 103
WEST BLOOMFIELD, MICHIGAN 48322
Tel. (248) 855-7400 Fax (248) 626-8461

CHETAN K. PATEL, M.D.
RACHEL S. ROHDE, M.D.
GINO R. SESSA, M.D.
JEFFREY D. SHAPIRO, M.D.
PAUL S. SHAPIRO, M.D.
RONALD S. SAVLOV, M.D.
BERIC TRUUMEES, M.D.
JAMES J. VERNER, M.D.

Patient Name: LOCKLEAR, GARY M Date: 09/16/2008

Diagnosis: 722.10 - Herniated Disk Lumbar Post Op Diagnosis:

- ☐ Degenerative Disc Disease
- ☐ Herniated disc
- ☐ Pain
- ☐ Sacroiliitis
- ☐ Osteoarthritis
- ☐ Spondylolisthesis
- ☐ Stenosis
- ☐ Tendonitis
- ☐ Tear, Rotator Cuff
- ☐ Fracture
- ☐ Dislocation
- ☐ Tear, meniscus
- ☐ Sprain, ligament tear

- ☐ Spinal fusion
- ☐ Laminectomy, Discectomy
- ☐ Meniscotomy, Arthroscopic
- ☐ Meniscetomy, Open
- ☐ Meniscal repair, arthroscopic
- ☐ Meniscal repair, open
- ☐ ACL reconstruction
- ☑ Debridement, arthroscopic
- ☐ Repair, rotator cuff
- ☐ Arthroplasty
- ☐ ORIF
- ☐ S/P fracture casting for
- ☐ Carpal tunnel release

Frequency of treatment (3x) 2x daily

Duration: Weeks FOUR Remark/Precautions

I certify that this Physical Therapy Program is indicated and necessary and that these services be rendered to the above named patient.

Signature of Physician

Area Involved:

- ☐ Cervical
- ☐ Thoracic
- ☑ Lumbar
- ☐ Sacroiliac

- ☐ Pelvis
- ☐ Hip
- ☐ Femur
- ☐ Knee
- ☐ Tibia/fibula
- ☐ Ankle
- ☐ Foot
- ☐ Toes

- ☐ Shoulder
- ☐ Humerus
- ☐ Elbow
- ☐ Forearm
- ☐ Wrist
- ☐ Hand
- ☐ Fingers

Modalities:

- ☑ Hot Packs
- ☑ Ultra Sound
- ☑ Electrical stimulation
- ☑ Massage
- ☐ Mechanical traction
  - ☐ Cervical
  - ☐ Lumbar
- ☐ Cold pack/ice
- ☐ Ice massage
- ☐ Whirlpool
- ☐ Post-Op as Indicated

Assessment Procedures
- ☑ Physical Therapy Evaluation

Therapeutic Exercise
- ☑ Isometric
- ☑ Active
- ☑ Passive
- ☑ Progressive resistive
- ☑ Spinal
- ☐ Postural body mechanics
- ☐ Cardiovascular
- ☑ Home program instruct
- ☐ A.D.L
- ☐ Gait Training

HealthStyles
PHYSICAL REHABILITATION

301 S. Lafayette, South Lyon, MI 48178
(248) 486-1110 Fax (248) 486-3318
12420 Grand River, Suite B, Brighton, MI 48116
(810) 229-3022 Fax (810) 229-2328

PLAN OF CARE

PATIENT NAME: Gary Locklear DOB: 12/12/50

DIAGNOSIS: [illegible]

PRECAUTIONS/TESTS:

MEDICAL HISTORY: [illegible]
(If significant)

SERVICE: ✓ PT ___ OT ___ SOCIAL WORK ___ SPEECH THERAPY

PLAN OF TREATMENT:
1) [illegible]
2) [illegible]
3) [illegible]
4) [illegible]
5) [illegible]
6)

GOALS:

STG:
1) [illegible]
2) [illegible]
3) [illegible]
4) [illegible]
5)
6)

LTG:
1) [illegible]
2) [illegible]
3) [illegible]
4) [illegible]
5) [illegible]
6)

THIS PATIENT WILL BE SEEN 3 TIMES PER WEEK FOR 4 WEEKS.

I CERTIFY ✓, RECERTIFY ___, THAT I HAVE EXAMINED THE PATIENT AND PHYSICAL THERAPY AND/OR OCCUPATIONAL THERAPY AND/OR SOCIAL SERVICES AND/OR SPEECH THERAPY IS NECESSARY AND THAT THESE SERVICES WILL BE PROVIDED WHILE THE PATIENT IS UNDER MY CARE. THE ABOVE PLAN OF CARE IS ESTABLISHED AND WILL BE REVIEWED EVERY 30 DAYS. I ESTIMATE THAT THESE SERVICES WILL BE NEEDED FOR 30 DAYS, AND BELIEVE THAT PATIENT'S REHABILITATION POTENTIAL IS ___. BY SIGNING THIS PLAN OF CARE, AUTHORIZATION IS GIVEN FOR THE ABOVE TREATMENT EFFECTIVE DATE OF INITIAL EVALUATION AND/OR DATE OF RECERTIFICATION 9-18-08 BY [signature]

DATE PHYSICIAN SIGNATURE

PHYSICIAN NAME: Dr [illegible]

THERAPIST SIGNATURE: [signature]
276.26

HealthStyles
PHYSICAL REHABILITATION

Physical • Occupational • Speech Therapy

Barbara Herzog, P.T.
301 S. Lafayette
South Lyon, MI 48178
(248) 486-1110

12420 Grand River
Suite B
Brighton, MI 48116
(810) 229-3022

EVALUATION

DATE: September 18, 2008
PATIENT NAME: Gary Locklear
PHYSICIAN NAME: Dr. Truumees
DIAGNOSIS: LBP, HNP S/P Laminectomy
D/O/B: 12/12/50

DATA-BASE

This is a 57-year-old male who comes to P.T. after having a laminectomy done approximately 8 weeks ago. Patient does a lot of physical work and is mostly healthy, however he started having some back/leg pain to the (R) with radiculopathy. The MRI in March showed a pinched nerve and HNP. He had no mechanism of injury. He did fall in February 2008 twice which increased his LBP. He had no specific time when the injury was sustained, just increased (R) radiculopathy. He did have 3 bouts of P.T. before surgery.

S: His pain is sharp in nature. He has positive muscle spasms and limited back motions. His pain is anywhere from level 2-5/10, specifically in the LB. The (R) hip has a sharp stabbing pain. He has restricted flexion with twisting/turning due to tightness. Increased sitting and duration increases his symptoms. Standing eliminates the pain at first, then with increased duration the symptoms get worse.

O: Posture: slouches, side sits, and changes positions a lot, especially with sleeping.
Palpation: tender along the (B) PS muscle.
ROM:
forward flexion: decreased 50%
(B) side-bending/rotation: 25%
LE Strength: 4/5 all cardinal planes.
Special tests:
Sensation: intact except decreased (L) big toe sensation which was apparent before surgery as well.
Flexibility: decreased overall
General health/fitness: good and he wants to get back to golfing.
Functional skills: patient is having difficulty with bending, lifting, sleeping, any job type physical activities, and up on his feet.

Treatment received: evaluation, MH/IFC stim, US x8' @ 1.5 w/cm^2 to L-spine/(B) PS muscles to increase STE, STM/MFR, biomechanical training, posture education, HEP instruction, transfer training, and TE to increase ROM, flexibility, strength, and core stability to improve overall function .

Problem list: 1)decreased flexibility, 2)decreased strength, 3)decreased postural awareness, 4)pain, 5)decreased sensation in the big toe, 6)decreased tolerance to functional activity.

A: Rehab potential is good.
STG:
Increase AROM 10%
Increase LE strength ½ grade
Increase core strength ½ grade
Decrease pain 2/10
LTG:
Increase AROM to WFL
Increase strength core/UE 1 grade
Independent HEP
Decrease pain by 2/10
Independent posture self correct 100%

P: Plan to see patient 3x/week for 4 weeks for treatment consisting of MH with IFC stim x15' supine to lumbar region to increase STE, US x8' @ 1.5 w/cm^2 to lumbar region to manage inflammation, STM/MFR/MET to lumbar region to decrease muscle spasm/tightness x15', TE to increase core stability, strength, flexibility, posture, and HEP instruction.

Thank you for your referral

DANA DUNN, D.P.T.

Exhibit 7

Rehabilitation Associates, P.C.

[1] DIPLOMATE, AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION
[2] DIPLOMATE, AMERICAN BOARD OF ELECTRODIAGNOSTIC MEDICINE

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Director, The Arts Doctor Program
Spine (Disorders / Osteoporosis
Cancer Rehabilitation

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Director, Rehabilitation Medicine
Cerebral, Spinal Cord Disorders
Multiple Sclerosis

JOHN T. MALTESE, MD[1,2]
Sports Medicine
Spinal Disorders
Geriatric Rehabilitation

MARTIN S. TABLER, MD[1,2]
Director, Sylvania Rehabilitation
Director, Prosthetics & Orthotics
Multilimb Rehabilitation

LISA E. GRANT, MD[1]
Osteoporosis
Sports Medicine
General Rehabilitation

DAVID J. SPITERI, MD[1]
Industrial Medicine
Acute Pain Management
Geriatric Rehabilitation

CHRISTINE O. CHAMBERLAIN, MD[1]
Geriatric Rehabilitation
Sports Medicine
Osteoporosis

GINO R. SESSA, MD[1,2]
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Sports Medicine
Osteoporosis Rehabilitation

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Geriatric Rehabilitation

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Acute Pain Management
Interventional Pain Management
Orthopedic Rehabilitation

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Acute Pain Management
General Rehabilitation

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William Beaumont Medical Building
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Royal Oak, MI 48073-6700
248-537-2210
Fax 248-[illegible]

Waterpointe Center
701 South Boulevard E., Suite 120
Rochester Hills, MI 48307-5715
248-852-[illegible]
Fax 248-852-[illegible]

Beaumont Medical Center
1453 S. Lapeer Road
Lake Orion, MI 48360
248-[illegible]-4250

January 9, 2009

RE: LOCKLEAR, GARY MRN: WC1207654

DATE OF BIRTH: 12/12/50

AGE: 58

REFERRING PHYSICIAN: Eeric Truumees, M.D.

CHIEF COMPLAINT: This patient presents to the office today for a consultation at the request of Dr. Eeric Truumees. He is complaining of low back pain.

HISTORY OF PRESENT ILLNESS: Mr. Locklear is a very pleasant 58-year-old gentleman being seen today at the request of Dr. Eeric Truumees for consultation and management of back pain. He tells me that he was involved in a work-related injury a year ago where he fell on black ice. He had a lot of bruising and pain at the time but he went back to work the next day and then slipped again. Apparently he works shipping automobiles by rail and does have to do a lot of climbing up and down the rail, ladders, and in and out of cars. He developed radicular symptoms in the left lower extremity. Initially he had x-rays which were normal. He was treated with physical therapy which did not help. He did not get any better, so he had an MRI which he tells me showed a herniated disk. HDS is not up for me to access this at this point, so I do not have these results. He had physical therapy again as well as an epidural steroid injection, neither of which helped. He saw Dr. Truumees. He underwent a laminectomy in August 2008. The pain was immediately relieved from the left leg. He was great for approximately two months, over 90% better, and he went back to work. However, slowly his pain has been increasing. He has a lot of back pain. He has pain over the right sacroiliac joint. Everything he does increases his pain. Lying down and heat do relieve it. At this point, he has no pain radiating down the leg. There is no numbness or tingling, it is all in the back.

He recently saw Dr. Truumees who wanted him to do work hardening program and an evaluation here for further management. He has not had a repeat MRI since surgery.

REVIEW OF SYSTEMS: Obtained and reviewed with the patient. Please see signed sheet in chart

PAST MEDICAL HISTORY: None.

(continued)

RE: LOCKLEAR, GARY MRN: WC1207654

PAST SURGICAL HISTORY: Appendectomy, laminectomy, right hand surgery, and left hand surgery.

CURRENT MEDICATIONS: Lipitor, Celebrex, omeprazole, Robaxin, lorazepam, Darvocet, and Micardis.

ALLERGIES: None.

SOCIAL HISTORY: He works shipping automobiles by rail. He does a lot of climbing in and out of cars and up and down ladders.

FAMILY HISTORY: Diabetes in his mother.

FUNCTIONAL HISTORY: He is ambulating independently. He is driving. He actually did go back to work in October 2008 and is trying to work. He is at his regular job at this point.

PHYSICAL EXAMINATION: Height: 6'1". Weight: 231.4. Blood pressure: 120/76. He is alert and oriented times three. Cranial nerves II through XII are grossly intact. Motor examination is 5/5 strength in the bilateral upper and lower extremities. Sensation is intact to light touch and pinprick throughout and reflexes are 2+ in the upper and lower extremities. On musculoskeletal examination, he has a negative SLR bilaterally. Pain-free range of motion of both hip joints, although these maneuvers do cause back pain. Spinous processes are tender to palpation in the lower lumbar area. He has significant tenderness over both sacroiliac joints. He has very limited lumbar flexion and a lot of pain with extension and rotation.

IMPRESSION AND PLAN:

1. Low back pain.
2. Sacroiliitis bilaterally.
3. History of lumbar radiculopathy status post laminectomy in August 2008 by Dr. Trummees.

At this point, seeing as his pain is so severe, I have increased his pain medication to Vicodin per his request. He was on Darvocet taking three daily. He will try to keep them under three a day. I would like to obtain an MRI with gadolinium to rule out scar tissue and to see if a trial of epidural steroid injections may be helpful. He tells me that he has had a lot of therapy since the pain started back after surgery and it has not helped at all. I would like to hold off on the work

(continued)

RE: LOCKLEAR, GARY MRN: WC1207654

hardening program until the MRI has been obtained to see if the injections might be helpful before work hardening.

Lisa B. Grant, M.D., F.A.A.P.M.R.

LBG/dmc

cc: Eeric Trummees, M.D.

D: 01/09/09
T: 01/11/08

Exhibit 8

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY

REGISTRATION DATA & INSURANCE INFORMATION
(Please Print)

Date: 3-27-09 Account # _____

Patient Name Gary M Locklear Married (✓) Single ( )

Date of Birth 12-12-50 Home Phone: 248 4860684

Home Address 1226 Silver Lake City/State Brighton Mi. Zip Code. 48116

Social Security # 371 52 4131 Driver's License # L246 271 603 944

Employer F.C.S. Employment Phone: 313 299 2135

Emergency Contact:

Name: Pamela Locklear Phone: 248 736 0458

INSURANCE INFORMATION

Subscriber: _____ Insurance Co: _____

Contract #: _____ Group #: _____ Subscriber's DOB: _____

Date Of Visit _____

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY
Health History Questionnaire

- Complete as best you can. Doing so now will save 30-45 minutes at your appointment.

Personal Information

Your Last Name	First Name	Middle Initial	Age
Locklear	Gary	M.	58

Street Address/Apt. No.	City	State	Zip
12266 Silver Lake	Brighton	Mi	48116

Home Phone	Work Phone	Cell/Mobile Phone
(248) 4860684	( )	(313) 220-6487

E-mail Address

Social Security Number: 371-52-4131 Date of Birth: 12-12-50

Emergency Contact Information

Contact's Last Name	First Name	Middle initial	Relationship
Locklear	Pamela	D.	Wife

Street Address/Apt. No.	City	State	Zip
12266 Silver Lake	Brighton	Mi	48116

Home Phone (248) 4860684 Work/Cell Phone (248) 736 0458 E-mail Address

How were you referred? ( ) Physician (X) Self/Other
If referred by physician, date referred _____

Physician Information

Physician's Last Name	First Name	Middle Initial

Street Address/Suite	City	State	Zip

Office Phone ( ) _____ Fax: ( ) _____ E-mail Address _____

Do you have a primary care physician?.....(✓) Yes ( ) No

Physician's Last Name	First Name	Middle Initial
Karadsheh	K	M.

Street Address/Suite 30701 Woodward Suite S-401 City Royal Oak State MI Zip 48073

Office Phone 248 435 4462 Fax( ) E-mail Address

Does your insurance require referrals for office visits and/or tests?..... ( ) Yes ( ) No

List all other physicians who should receive results of your consultation

Physician's Last Name	First Name	Middle Initial
Twumees	Eric	

Street Address/Suite	City	State	Zip
26025 Lahser Suite 200B	Southfield	MI	48033

Office Phone	Fax	E-mail Address
248 855 7400	248 355 4960	

Physician's Last Name	First Name	Middle Initial

Street Address/Suite	City	State	Zip

Office Phone	Fax	E-mail Address

Physician's Last Name	First Name	Middle Initial

Street Address/Suite	City	State	Zip

Office Phone	Fax	E-mail Address

LUCIA ZAMORANO, MD, PLC

NEUROLOGICAL SURGERY

Medical History

Describe (in your own words) how your illness started and what test(s) you had done before your appointment at Lucia Zamorano, MD, PLC

Refer to chart review

06/08 [illegible]

01/08 [illegible]

Surgery

Have you ever had cancer surgery? If "yes," describe below.....( )Yes (X)No

Month/Year of Surgery	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after surgery:

Radiation Therapy

Have you ever had radiation therapy? If "yes," describe below.....( ) Yes (X)No

Start Date - End Date	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after radiation therapy:

Chemotherapy

Have you ever had chemotherapy? If "yes," describe below.....( ) Yes (X)No

Start Date ~ End Date	Chemotherapy Drug/Regimen	Hospital	Physician

Describe any problem(s) you experienced during or after chemotherapy:

Medical History: Noncancer

How was your health before your diagnosis?..... ( ) Excellent (✓) Good ( ) Fair ( ) Poor
How do you feel right now?..... ( ) Excellent ( ) Good ( ) Fair (✓) Poor

Medical Illnesses or Conditions: List all noncancer illnesses or conditions (for example, diabetes, heart disease, high blood pressure) starting with most recent.

Illness/Condition	Date Diagnosed	Treatment	Physician
high blood pressure	2007	medication	Kavadsheh
Arthritis	2005	medication	"
Acid reflux	2000	medication	"
Cholesterol	2004	medication	"
nerves	2008	medication	"
Back Pain	2008	medication	Trummees

Hospitalizations & Operations: List all noncancer hospitalizations and operations starting with most recent.

Reason for Hospitalization	Date(s) Hospitalized	Hospital	Physician
Back Surgery	7-23-08	Beaumont	Trummees
Knee Surgery	1985	Oakwood	
Appendixe	1975	Garden City	

Medications: List all medications you are now taking (including vitamins and nonprescription drugs) and doses starting with most recent. Bring all medications to your first visit.

Medication	Date Prescribed	Dosage	Frequency
Micardis tabs 1's	1-8-09	forty	1 daily
Omeprazole	1-8-09	20 mg	1 daily
Lorazepam	1-8-09	1 mg	1 daily
Lipitor	1-8-09	20 mg	1 daily
Celebrex	1-8-09	200 mg	1 "
Propoxyphen-APAP	2-19-09	100-650 mg tev	1 every 4-6 hours
Methocarbamol	2-19-09	500 mg.	1 twice a day

Medical Allergies	Yes	No	Don't Know
Are you allergic to the dye used in X-rays?		✓	
Are you allergic to latex?		✓	
Are you allergic to medications (for example, Penicillin)?		✓	

Medication	Date of Reaction	Type of Allergic Reaction		

Family Health History

Include blood relatives, only — whether or not diagnosed with cancer. Do not include anyone adopted, foster, step-relatives or those related by marriage.

Relative	Age	Alive?		Had Cancer?		If "Yes," List Type(s) (breast, lung)	Other Medical Problems?		If "Yes," List Conditions (heart disease, kidney failure)
		Yes	No	Yes	No		Yes	No	
Your Mother	78	✓		✓		Skin	✓		Parkinson
Your Father			✓		✓		✓		Prostate tear
Your Mother's Mother			✓		✓				Heart Attack
Your Mother's Father			✓						
Your Father's Mother			✓		✓			✓	
Your Father's Father			✓						
Daughter 1	38	✓			✓			✓	
Daughter 2									
Daughter 3									
Daughter 4									
Son1	41	✓			✓			✓	
Son 2									
Son 3									
Son 4									
Sister 1	55	✓		✓		Cervical		✓	
Sister 2	55	✓			✓			✓	
Sister 3	53	✓			✓			✓	
Sister 4	51	✓		✓		Cervical		✓	
Brother 1	60	✓			✓			✓	
Brother 2	49	✓			✓			✓	
Brother 3									
Brother 4									
Other Blood Relatives:									

Other illnesses that "run" in your family:

Social History	Yes	No	Don't Know
Marital status: ✓Married __ Single __ Separated __ Divorced Widowed			
Number of dependents at home: 2	2		
Education: ✓Grade school ✓High school __ College __ Other:			
Main language: ✓English __ Spanish Arabic __ Other:			
Need a translator?		✓	
Have reliable transportation to medical appointments?	✓		
Have insurance coverage for prescription drugs?	✓		
Have advanced directive/durable power of attorney? (If "yes," bring to appointment,)		✓	
Have family/friends to help you during your treatment?	✓		
Have emotional support from family members/friends?	✓		
Have someone living with you?	✓		
If "yes," name: Pam Locklear Phone: (248)486-0684			
Need help coping with your diagnosis?		✓	
If "yes," are you receiving help?			
If "yes," name: Location:			
Does your family need help coping with your diagnosis?		✓	
Are you currently being abused physically, sexually or emotionally?		✓	
Would you like to speak with a cancer counselor?		✓	

Occupation/Work History & Environmental Exposure	Yes	No	Don't Know
What is your current occupation? Manager			
Did you previously have a different occupation?	✓		
Were you ever exposed to the following (work or elsewhere):			
Asbestos			✓
Chronic Fumes		✓	
Chronic Dust		✓	
Radiation		✓	
Toxic Chemicals		✓	
Other (list)		✓	

Tobacco, Alcohol & Other Substance Use	Yes	No	Don't Know
Do you use? (✓)Cigarettes ( ) cigars ( )pipe ( ) chewing tobacco snuff *(check all that apply)*			
How much do you use per day? 15 cigs Number of years? 40 yrs			
Did you use?. (✓)cigarettes ( )cigars ( )pipe ( )chewing tobacco snuff *(check all that apply)*			
How much did you use per day? Number of years? When did you stop?			
Have you been exposed to secondhand smoke at home or work?			
Do you drink alcoholic beverages regularly?		✓	
Do you drink alcoholic beverages on social occasions, only?	✓		
Has alcohol ever interfered with your personal/professional life?		✓	
Did you, or do you, use marijuana?	✓		
Have you have used cocaine, heroin or other illegal substances?		✓	

Review of Systems

If you are currently experiencing — or previously experienced — any of the following to a significant degree, explain on the back of this page.

General	Yes	No	Don't Know
Fever		✓	
Sweats		✓	
Weakness		✓	
Fatigue		✓	
Weight Loss		✓	

Pain	Level
Average pain most days:	0 1 2 3 4 5 (6) 7 8 9 10 (none/low) (worst)
Where does it hurt? Lower Back	
Staying the same or getting worse?	( )Same (✓)Worse
What are you taking for it? Propoxyphen	
Does this help? No	

Skin	Yes	No	Don't Know
Excessive sun exposure		✓	
Blistering/burns		✓	
Use sunscreen		✓	
Dark or pigmented skin lesion		✓	
Dark or pigmented skin lesion removed		✓	
Melanoma		✓	
Bleeding skin lesion		✓	
Skin cancer		✓	
Psoriasis		✓	
Chronic rash		✓	
Vitiligo		✓	
Birthmark		✓	
Family member with dysplascic nevus syndrome		✓	

Eyes	Yes	No	Don't Know
Lost vision		✓	
Wear glasses Cataracts	✓		
Glaucoma		✓	

Ears	Yes	No	Don't Know
Lost hearing		✓	
Ringing in your ears		✓	

Sinuses	Yes	No	Don't Know
Sinus trouble		✓	
Nosebleeds		✓	

Mouth	Yes	No	Don't Know
Dental problems		✓	
Wear dentures	✓		
Sore tongue		✓	

Neck	Yes	No	Don't Know
Swollen glands		✓	
Laryngitis		✓	
Hoarseness		✓	

Breast	Yes	No	Don't Know
Breast biopsy		✓	
Breast cancer		✓	
Nipple discharge		✓	
Breast lumps		✓	
Cystic breast disease		✓	
Breast infection		✓	
Mammogram		✓	
Hormone replacement therapy		✓	
Breastfed any children		✓	
If "yes" how long in total months:			

Lungs	Yes	No	Don't Know
Cough every day		✓	
Cough, produce sputum (phlegm) most days		✓	
Blood in your sputum		✓	
Pneumonia		✓	
Bronchitis		✓	
Emphysema		✓	
Pleurisy		✓	
Tuberculosis		✓	
Asthma		✓	
Short of breath with activity		✓	
Short of breath at rest		✓	
Frequent colds		✓	
Heart, Blood Vessels	Yes	No	Don't Know
Chest pain (Angina)		✓	
Chest pressure		✓	
Heart attack		✓	
Short of breath at night		✓	
Heart murmur		✓	
Rapid heartbeat that required treatment		✓	
Swollen ankles		✓	
Leg cramps at night		✓	
Leg cramps when walking		✓	
Rheumatic fever		✓	
Congenital heart disease		✓	

Gastrointestinal	Yes	No	Don't Know
Lost appetite		✓	
Recent weight change		✓	
If yes, amount:	Loss	C	Pain
Excess saliva		✓	
Swallowing problems		✓	
Difficult		✓	
If yes, date started:		✓	
Solids stick		✓	
If yes, where:		✓	
Pain		✓	
If yes, date started:		✓	
Choking		✓	
Food comes out your nose		✓	
Heartburn	✓		
Ulcer		✓	
Endoscopy (upper GI, colonoscopy, etc*)		✓	
Nausea		✓	
Vomiting		✓	
Vomit blood		✓	
Diarrhea		✓	
Upset stomach (food related)		✓	
Constipation		✓	
Black bowel movements		✓	
Bloody bowel movements		✓	
Yellow or jaundiced		✓	
Hepatitis		✓	
Gall bladder problems		✓	
Cirrhosis		✓	

Genitourinary	Yes	No	Don't Know
Kidney problems		✓	
Frequent urination		✓	
Painful urination		✓	
Urinate at night	✓		
Blood in urine		✓	
Kidney stones		✓	
Genitourinary: Men	**Yes**	**No**	**Don't Know**
Difficulty starting/ stopping urination		✓	
Sexual performance problems		✓	
Elevated prostate blood test (PSA)		✓	
Prostate biopsy		✓	
Swollen/painful testicle		✓	
Genitourinary: Women	**Yes**	**No**	**Don't Know**
Age started menstruating:			
Irregular or painful menstruation			
Still menstruating			
Date of last menstrual period:			
Age stopped menstruating:			
Painful intercourse			
Bleeding following intercourse			
Endome trios is			
Did your mother take estrogens when pregnant with you?			
Date of your last pap smear:			
Pregnant now			
Number of pregnancies:			
Number of children: Number of miscarriages:			
Age at first pregnancy:			

Neurological	Yes	No	Don't Know
Dominant hand:	Right		Left
Headaches		✓	
Seizure		✓	
Double vision		✓	
Blurred vision		✓	
Weakness in extremity		✓	
Numbness	✓		
Stroke		✓	
Migraine headaches		✓	
Forgetfulness		✓	
Confusion		✓	
Hematologic	**Yes**	**No**	**Don't Know**
Blood transfusion		✓	
Rejected as blood donor		✓	
Bruise or bleed easily		✓	
Anemic		✓	
Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alleve)	✓		
Swollen glands		✓	
Extremities & Back	**Yes**	**No**	**Don't Know**
Arthritis	✓		
Back pain	✓		
Broken bone		✓	
Swollen joints	✓		
Endocrine/Glands	**Yes**	**No**	**Don't Know**
Diabetes mellitus		✓	
Thyroid disease		✓	
Other endocrine/gland conditions (list)		✓	

Additional questions you have:

Physician Reviewer _____

Date _____

LUCIA ZAMORANO, MD, PLC

NEUROLOGICAL SURGERY

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION AND CONSENT TO INFORMATION IN ELECTRONIC FORM

1. Referring Physician:

Name: _____
Address: _____
City/State/Zip: _____
Phone#: _____

2. Primary Care Physician:

Name: K. M. Karadsheh
Address: 30701 Woodward
City/State/Zip: Royal Oak MI. 48073
Phone#: 248 435 4462

3. Automobile Accident (if FULL Auto):

Agency: _____
Address: _____
City/State/Zip: _____
Phone#: _____

4. Workers Compensation:

Agency: _____
Address: _____
City/State/Zip: _____
Phone#: _____

5. √ I give the doctor permission to speak to the following family member and/or friend:

Name: Gary Locklear Relationship: Wife
Name: _____ Relationship: _____

6. __ I give the doctor permission to release all medical information and records to:

Name: _____ Relationship/Agency: _____

Name: _____ Relationship/Agency: _____

7. ___ I do not wish to have information released to anyone at this time.

I have reviewed the above information and verify that it is correct.

Patient Printed Name: Gary M. Locklear Date 3-27-09
Patient Signature: Gary M Locklear Date 3-27-09

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY

	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Initials															
Height															
Weight															
Blood Pressure															
Pulse															
Temperature															
Respiratory Rate															
Poise Oximetry															
Pain VAS (0-10)	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Fatigue Score(0-10)															
Sleeping Problems															
Concerns															
Appetite Change															
Port/CVC															
Recent tests/procedures															
New medications															
New allergies															
Change in Primary MD															
Performance status															

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY

MEDICATION Dose/Frequency	Date	Date	Date	Date	Date	Date	Date	Date

ALLERGIES

Date	Allergen	Reaction

IMMUNIZATIONS Date	Date	Date

Exhibit 9

Oakland MRI

5119 Rochester Road
Troy, Michigan 48085

www.oaklandmri.net

Phone 248.740.0777
Fax 248.740.9777
888.MRIMRAS (674.6727)

All Physicians certified by the American Board of Radiology

PATIENT NAME: LOCKLEAR, GARY
DATE OF BIRTH: 12-12-50
DATE OF EXAMINATION: 4-9-09
REFERRING PHYSICIAN: Dr. Zamorano

Clinical Information: Fall on ice in February 2008, status post surgery.
Comparison: A report from an MRI of lumbar spine dated 1-19-09.

MRI OF THE LUMBAR SPINE WITH AND WITHOUT CONTRAST:

Axial and sagittal T1 and T2 MR evaluation of the lumbar spine is performed. Following intravenous administration of 20 cc of gadolinium, enhanced axial and sagittal T1 MR imaging is included.

Conus terminates in normal position posteriorly at T12. Vertebral body heights are maintained.

T12-L1: Normal.
L1-L2: There are mild spondylitic changes posteriorly. There is no disc herniation.
L2-L3: There are moderate spondylitic changes posteriorly. There is no disc herniation.
L3-L4: There is disc space narrowing and diffuse disc bulging and along with spondylitic changes posteriorly contribute to moderate bilateral symmetric inferior nerve root recess encroachment. There is no disc herniation. There is encroachment of the anterior epidural space and disc bulge.
L4-L5: There are advanced spondylitic changes posteriorly with disc space narrowing, disc dessication signal changes, and diffuse disc bulging all of which contribute along with spondylitic changes to central canal narrowing and bilateral high-grade neural foraminal encroachment at this level.
L5-S1: There is disc space narrowing and diffuse disc bulging encroaching significantly anterior epidural space along with spondylitic changes contributing moderate bilateral symmetric inferior nerve root recess encroachment.

There is laminectomy defect on the left at L4-L5.

Following the intravenous administration of gadolinium contrast, there is enhancing epidural scar at L4-L5 particularly posteriorly without focal disc protrusion to suggest disc herniation.

IMPRESSION:
1. Status post left hemilaminectomy defect at L4-L5 with enhancing epidural scar about the L4-L5 and L5-S1 nerve roots as well as at the epidural space. There is no MR evidence for recurrent or residual disc herniation.
2. Anterolisthesis of L4 on L5 as before with compensatory irregular facet spondylitic changes posteriorly at this level.
3. Multilevel spondylitic changes posteriorly, which along with diffuse disc bulging at L3-L4, L4-L5, and L5-S1 contribute to bilateral inferior nerve root recess encroachment.

Anthony A. Bennett, M.D.
AAB/bgg.BZD
DT: 4-10-09

Oakland MRI

5119 Rochester Road
Troy, Michigan 48085

www.oaklandmri.net

Phone 248.740.0777
Fax 248.740.9777
888.MRIMRAS (674.6727)

All Physicians certified by the American Board of Radiology

PATIENT NAME: LOCKLEAR, GARY
DATE OF BIRTH: 12-12-40
DATE OF EXAMINATION: 4-27-09
REFERRING PHYSICIAN: Dr. Zamorano

Clinical Information: Neck pain with radiating symptoms to right two fingers with numbness and tingling. There is decreased range of movement and also right shoulder pain.

Comparison: None.

MRI OF THE CERVICAL SPINE WITHOUT CONTRAST:

Axial and sagittal T1 and T2 MR evaluation of the cervical spine is performed.

There are mild areas of increased T2 signal in the cervical spinal cord at C3-C4, C4-C5, and C5-C6. Cerebellar tonsils are normal in position.

C2-C3: Normal.

C3-C4: There is disc space narrowing and broad-based central disc herniation encroaches anteriorly the epidural space and in fact approximates the anterior surface of the cervical cord. There are mild spondylitic changes posteriorly, however, without significant neuroforaminal encroachment.

C4-C5: There is broad-based central disc herniation encroaches anteriorly the epidural space and approximates the anterior surface of the cervical cord. There is mild spondylitic changes posteriorly without high-grade or with bilateral neuroforaminal encroachment particularly on the right at this level.

C5-C6: There is a large bilobed disc herniation measures 1.5 cm in width and in depth 9 mm particularly right of midline encroaches severely the anterior epidural space on the right and effaces the right anterior aspect of the cervical cord displacing it posteriorly. There are spondylitic changes posteriorly as well contributing to right-sided neuroforaminal encroachment at this level.

C6-C7: There is a small left paracentral disc herniation mildly encroaching the left anterior epidural space. Neuroforamina is without high-grade narrowings.

IMPRESSION:

1. Large disc herniation at C5-C6 particularly with the right paracentral component effacing the right anterior epidural space and deforming the anterior surface of the cervical cord displacing it posteriorly.
2. Small broad-based central disc herniations at C4-C5 and C3-C4 encroaching the anterior epidural space and in fact approximating the anterior surface of the cervical cord.
3. Multilevel spondylitic changes posteriorly in particular contributing to high-grade right-sided neuroforaminal encroachment at C4-C5 and C5-C6.
4. Areas of increased signal in the cervical cord at C3-C4, C4-C5, and C5-C6 may reflect superimposed cervical spinal myelitis.

Oakland MRI

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Troy, Michigan 48085

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MRI OF THE RIGHT SHOULDER WITHOUT CONTRAST:

Multiplanar and multisequence MR imaging of the right shoulder is performed. Study is somewhat degraded by patient's motion.

There is a complex full-thickness tear at the musculotendinous junction of the rotator cuff tendon. There is small joint effusion with communicating fluid to the subdeltoid bursa. There is subchondral cystic change of the superolateral humeral head. The glenohumeral articulation is narrowed with a complex degenerative tear glenoid labrum. There is advanced degenerative change at the AC joint. Biceps tendon is in normal position. There is subcoracoid fluid as well.

There is irregular appearance to the biceps tendon in the sheet with fluid about the tendon sheath as well.

IMPRESSION:

1. Complex full-thickness tear musculotendinous junction of the rotator cuff tendon without retraction.
2. Complex degenerative tear glenoid labrum.
3. Degenerative change superolateral humeral head and AC joint.
4. Thickening with increased signal within the biceps tendon with fluid about it presumably reflecting biceps tenosynovitis.
5. Degenerative small joint effusion with communicating fluid in the subdeltoid bursa.

Anthony A. Bennett, M.D.
AAB/bzr.BZD
DT: 4-28-09

Oakland MRI

5119 Rochester Road
Troy, Michigan 48085

www.oaklandmri.net

Phone 248.740.0777
Fax 248.740.9777
888.MRIMRAS (674.6727)

All Physicians certified by the American Board of Radiology

PATIENT NAME: LOCKLEAR, GARY
DATE OF BIRTH: 12-12-50
DATE OF EXAMINATION: 7-6-09
REFERRING PHYSICIAN: Dr.

Clinical Information: History of prior cervical spinal surgery in June 2009. Patient describes pain radiating posterior to the right side of the neck.

Comparison: 4-27-09.

MRI OF THE CERVICAL SPINE WITH AND WITHOUT CONTRAST:

Axial and sagittal T1 and T2 MR evaluation of the cervical spine is performed. Following the intravenous administration of 20 cc of gadolinium contrast, enhanced axial and sagittal T1 MR imaging is included.

From the prior patient is status post anterior cervical fusion at C4-C5 and C5-C6.

The cervical spinal cord has mild areas of increased T2 signal in the cord at C3-C4, C4-C5, and C5-C6 as before. Cerebellar tonsils are normal in position.

C2-C3: Normal.

C3-C4: There is disc space narrowing with a broad-based central disc protrusion mildly encroaches the anterior epidural space and approximating the anterior surface of the cervical cord slightly greatest so on the right than left. There are spondylitic changes posteriorly. Neural foramina are widely patent.

C4-C5: The broad-based central disc herniation in part persists mildly encroaching the epidural space. There are mild spondylitic changes posteriorly contributing to mild bilateral symmetric inferior nerve root recess encroachment at this level.

C5-C6: The bilobed disc herniation previously detailed is improved with residua mildly encroaching the anterior epidural space. There is enhancing epidural scar at the same levels. There are as well mild spondylitic changes posteriorly.

C6-C7: The small left paracentral disc herniation persists as before.

IMPRESSION: From the prior, status post anterior cervical fusion at C4-C5 and C5-C6 with mild residual disc protrusions at the same levels particularly at C5-C6 right of midline.

Anthony A. Bennett, M.D.
AAB/bgg.BZD
DT: 7-7-09

Exhibit 10

JUL. 14. 2009 1:35PM RITEWAY TRANSPORT NO. 820 P. 3

May 20 09 04:42p Fax 2483474735 p.2

Cervical-Stim® Order Form

ORTHOFIX

Model Number: 2505

Territory Manager: Eric Hunter

PATIENT INFORMATION

NAME: Gary Locklear
ADDRESS: 12266 Silver Lake Rd
CITY, STATE, ZIP: Brighton, MI 48116
PHONE #: 248-484-0684
SOCIAL SECURITY #: 371-52-4131
DATE OF BIRTH: 12-12-50 SEX: ☒M ☐F
EMPLOYER (of the insured):
ADDRESS:
CITY, STATE, ZIP:
PHONE #: 313-220-6487 *

INSURANCE COVERAGE (✓ONE): ☒Standard ☐Auto Liability ☒Workers Comp ☐Medicaid ☐Medicare Effective Date: __-__-__
ATTORNEY NAME: Robert Blamer
PHONE #: 734-261-2400
☐ HMO-PCP Referred by:
PHONE #: 734-261-4510 fax

PRIMARY INSURANCE

INSURED: Gary Locklear
Relationship to Patient: ☒Self ☐Spouse ☐Parent ☐Employer ☐Other
SS#: 371-52-4131
POL/I.D./CLM#: 4410760
GROUP #:
CARRIER: Independent Claims Service
PHONE #: 313-299-2115
CONTACT: Bridget Green
ADDRESS: 9900 Pelham Rd
CITY, STATE, ZIP: Taylor, MI 48180

SECONDARY INSURANCE

INSURED: Gary Locklear
Relationship to Patient: ☒Self ☐Spouse ☐Parent ☐Employer ☐Other
SS#: 371-52-4131
POL/I.D./CLM#: GHP 93148 2974
GROUP #: 83500
CARRIER: BCBS
PHONE #:
CONTACT:
ADDRESS:
CITY, STATE, ZIP:

MEDICAL INFORMATION

Date of ☒Injury or ☐Diagnosis (✓ONE): 2-10-08

Diagnosis (list all that apply) — Levels
☐Degenerative Disc Disease __ to __
☐Internal Disc Disruption __ to __
☒Herniated Nucleus Pulposus C2 to C6
☐Pseudarthrosis (Failed Fusion) __ to __
☐Spondylolisthesis Grade __ __ to __
☐Spinal Stenosis __ to __
☐Spondylolysis __ to __
☐Instability __ to __
☐Radiculopathy
☒Other: spondylitic changes C4-C6

Risk Factors
☐Smoking (ppd)
☐Nicotine
☒Multilevel Fusion
☐Gross Instability
☐Osteoporosis
☒Diabetes
☐Obesity
☐Bone Depleting Medication

☐No Instrumentation
☐Previous Back Surgery
☐Previous Failed Fusion
☐Infection
☐Arthritis
☐Allo/Mixed graft
☐Other

Proposed Treatment
☒Fusion Surgery Date: 6/1 Levels: C4 to C6
☒ACDF ☐Posterior Fusion ☐360°
Graft Source: ☐Allograft ☐Autograft ☐Mixed
☐Fixation: Type
[ ]Instrumentation: Type
☒Other: [illegible]
☐Brace:

Previous Treatment — Levels
☐Fusion Surgery Date: __/__/__ __ to __
☐ACDF ☐Posterior Fusion ☐360°
Graft Source: ☐Allograft ☐Autograft ☐Mixed
☐Physical Therapy ☐Bracing ☐Pain Management

	Date	Levels
Discectomy	__/__/__	__ to __
Fixation	__/__/__	__ to __
Fixation Removal	__/__/__	__ to __
Instrumentation	__/__/__	__ to __
Laminectomy	__/__/__	__ to __

PHYSICIAN

NAME: Lucia Zamorano, M.D.
ADDRESS: 31500 Telegraph Rd
CITY, STATE, ZIP: Bingham Farms, MI
PHONE #: 248-723-2477
NPI #: 1770579107

PAN 571350-0001 Rev F
CS-070-VA-PLUS © Orthofix Inc. 3/2007

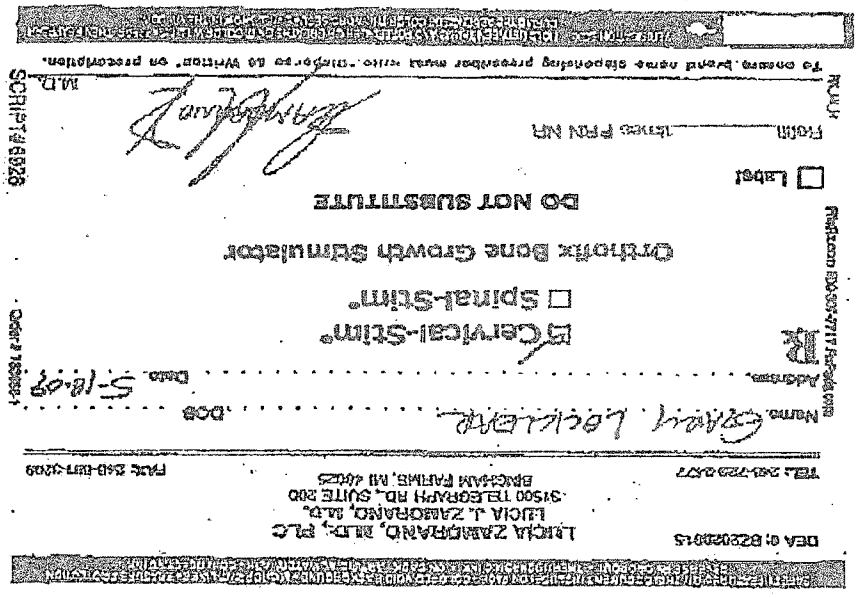


Exhibit 11

Consultation

* Final Report *

Result type:	Consultation
Result date:	02 June 2009 00:00
Result status:	Auth (Verified)
Result title:	32
Performed by:	AYOUB MD, AHMED E on 02 June 2009 10:04
Verified by:	AYOUB MD, AHMED E on 03 June 2009 16:11
Encounter info:	122229610, HARPER-HUTZEL, Inpatient-Discharged, 06/01/09 - 06/02/09

* Final Report *

32 (Verified)

DETROIT MEDICAL CENTER
WAYNE STATE UNIVERSITY
HARPER UNIVERSITY HOSPITAL

CONSULTATION

PATIENT:
LOCKLEAR, GARY

NURSING UNIT:4WS
ROOM/BED:4407/02

MR #:801304794
DMC #:11122041
ACCT #:0122229610
DOB: 12/12/1950

DATE OF ADMISSION: 06/01/2009

REFERRING PHYSICIAN: Lucia J Zamorano, MD

DATE OF CONSULTATION: 06/02/2009

CONSULTING PHYSICIAN: Ahmed E. Ayoub, MD

REASON FOR CONSULTATION: Inpatient rehab service.

BRIEF HISTORY: This is a 58-year-old right hand dominant white male who was admitted to this service on June 1, 2009, with chief complaint of right shoulder pain and radiating to the right arm.

The patient underwent C4-C5, C5-C6 anterior cervical dissection/fusion.

During his hospital course, the patient was seen by internal medicine consult.

PAST MEDICAL HISTORY:
1. Vascular disease.
2. Hypertension.
3. Obstructive sleep apnea.

FAMILY MEDICAL HISTORY: Noncontributory.

SOCIAL HISTORY: The patient lives with his spouse in a ranch style house, had history of smoking and alcoholic use, negative for drug use. His wife is not able to help him because she is a MS patient.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

CURRENT MEDICATIONS: Hydrochlorothiazide, and for the rest of the medication, refer to the EMR.

REVIEW OF SYSTEMS: Was negative for chest pain, mild swallow problem secondary to pain in the anterior cervical area. Positive for voiding.

PHYSICAL EXAMINATION: VITAL SIGNS: 120/70, 18 for respiratory rate, 36.1 for temperature.
GENERAL APPEARANCE: The patient is alert and awake, oriented to himself and place.
HEENT EXAMINATION: Normocephalic. Extraocular muscles intact bilaterally. Positive for anterior cervical dressing. EXTREMITIES: Negative for calf tenderness bilaterally.
NEURO EXAMINATION: The patient is alert and awake, oriented to self and place. Follows simple and complex commands. CRANIAL NERVE EXAMINATION: II-XII are intact.
MOTOR EXAMINATION: In handgrip elbow flexion, wrist extension is 5/5, and ankle dorsiflexion and plantar flexion and hip flexion is 5/5.
CEREBELLA: Cerebellar testing, absent dysarthria.

The patient was able to ambulate in front of me a few steps in place with a good standing balance.

ASSESSMENT: This is a 58-year-old with a history of disk herniation in the past, with status post anterior cervical dissection, fusion, with decline in activities of daily living transfers and mobility.

RECOMMENDATION:
1. The patient will benefit from DVT prophylaxis if medically possible.
2. The patient will benefit from physical and occupational therapy evaluation.
3. The patient will benefit from pain service consult if pain is not well controlled.
4. If the patient is able to ambulate with service 50 feet x2 and modified independent level as well as going up and down the stairs at least couple of steps in a modified independent level as well as for occupational therapy activity in a modified independent level, then the patient will be a candidate for the home therapy consult when he is medically stable.
5. If not meeting this criteria, then the patient will can be considered for possible rehab program prior to discharge home.

I had discussed this recommendation with the patient who was interested to go

home when he is medically stable because he anticipate that he will be able to meet this criteria.

Again Dr. Zamorano, thank you for consult. If you have any questions regarding our assessment and recommendation plan, please do not hesitate to give us a call.

If the report has been electronically signed, see completed action list below.

Ahmed E. Ayoub, MD
SIGNATURE OF CONSULTING PHYSICIAN/DATE

D: 06/02/2009 10:04:27
T: 06/02/2009 10:35:41
MEDQ/Job #358424

Dictated by: Ahmed E. Ayoub, MD

cc: Lucia J Zamorano, MD

Completed Action List:
* Perform by AYOUB MD, AHMED E on 02 June 2009 10:04
* Transcribe by TRANSCRIPTION, MEDQUIST on 02 June 2009 10:35
* Sign by AYOUB MD, AHMED E on 03 June 2009 16:11 03 June 2009 16:11
* Modify by AYOUB MD, AHMED E on 03 June 2009 16:11
* VERIFY by AYOUB MD, AHMED E on 03 June 2009 16:11

Admit Notice

LOCKLEAR, GARY - H-801304794

* Final Report *

Result type:	Admit Notice
Result date:	01 June 2009 06:00
Result status:	Auth (Verified)
Result title:	ADMNOT
Performed by:	ADMIT, NOTE on 01 June 2009 06:00
Encounter info:	122229610, HARPER-HUTZEL, Inpatient-Discharged, 06/01/09 - 06/02/09

* Final Report *

ADMNOT

Dr. LUCIA ZAMORANO,

Your patient GARY LOCKLEAR has been admitted to Harper University Hospital with a chief complaint of CA/C5+C5/C6 DISC HERN. GARY LOCKLEAR has been admitted to POH/POH/07.

A discharge notice will be forwarded to your office upon GARY LOCKLEAR's release from the hospital.

Sincerely,

Harper University Hospital

Completed Action List:
* Perform by ADMIT, NOTE on 01 June 2009 06:00
* Transcribe by ADMIT, NOTE on 01 June 2009 06:00

Printed by: MAYS, DYNEISE
Printed on: 10/07/09 09:03

Operative Report

LOCKLEAR, GARY - H-801304794

* Final Report *

Result type:	Operative Report
Result date:	01 June 2009 00:00
Result status:	Auth (Verified)
Result title:	34
Performed by:	ZAMORANO MD, LUCIA J on 02 June 2009 08:06
Verified by:	ZAMORANO MD, LUCIA J on 02 August 2009 17:34
Encounter info:	122229610, HARPER-HUTZEL, Inpatient-Discharged, 06/01/09 - 06/02/09

* Final Report *

34 (Verified)

DETROIT MEDICAL CENTER
WAYNE STATE UNIVERSITY
HARPER UNIVERSITY HOSPITAL

OPERATIVE NOTE

PATIENT:
LOCKLEAR, GARY

MR #:801304794
DMC #:11122041
ACCT #:0122229610
DOB: 12/12/1950

NURSING UNIT:
ROOM/BED:4407/02

DATE OF SURGERY: 06/01/2009

SURGEON: Lucia J Zamorano, MD

ASSISTANT: Audrey Murray, PA

PREOPERATIVE DIAGNOSIS:
1. C4-C5 and C5-C6 stenosis.
2. Cervical stenosis secondary to herniated disk.
3. Extruded C5-C6 disk.

POSTOPERATIVE DIAGNOSIS:
1. C4-C5 and C5-C6 stenosis.
2. Cervical stenosis secondary to herniated disk.
3. Extruded C5-C6 disk.

PROCEDURE:
1. Arthrodesis for preparation of interdisk space of C5-C6.
2. Decompression of nerve root and cord at C5-C6.
3. Arthrodesis for preparation for interdisk space of C4-C5.
4. Decompression of cord C4-C5.
5. Allograft (2 levels).
6. Placement of cage at C4-C5 and C5-C6.

7. Anteriro instrumentation C4-C6.
8. Microsurgery microdissection.
9. Fluoroscopy.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: 5 mL.

INDICATIONS: This patient is a 58-year-old with a history of a work-related injury after which he started presenting with low back pain secondary to lumbar disk disease and cervical pain secondary to cervical disk disease. The patient had surgery of the lumbar area for disk with decompression and laminectomy. The cervical pain continued getting worse and it developed radiation to the right arm with numbness and signs of radiculopathy of C6. An MRI was done that shows a stenosis at C4-C5 and C5-C6 secondary to herniated disk with an extruded disk at C5-C6 and compression of the C6 nerve root. The patient was recommended to have cervical disk fusion with decompression of his 2 levels and removal of extruded disk. The benefits, risks and possible complications of the procedure were explained to the patient and a signed consent was obtained.

PROCEDURE: The patient was intubated and placed under general anesthesia. The position was supine with saline bag between his shoulders. The neck was prepped in habitual fashion. The C-arm was brought into the field and the levels of C4, C5 and C6 vertebra was marked. A transverse incision was done at the level of C5. The platysma was incised. The prevertebral space was entered in front of the sternocleidomastoid. Using a Cloward retractor, the prevertebral disk space was dissected. We proceeded at this moment to confirm with a needle marker the levels of C4, C5 and C6. The shadow lineretractor was placed. We positioned the pins in the level of C4, C5 and C6. An incision was done at the level of C5-C6. The annulus was incised and the disk was removed. Surgical microscope was brought into the field and acute decompression was done. We visualized the ruptured ligament with disk material extruded. We proceeded
to remove the ligament to expand the opening and being able to remove the extruded fragment of disk at the level of C5-C6. Good decompression of the nerve root, the dural contents were obtained. We proceeded at this moment to use different sizes and we decided to use a 6 mm size cage. An LDR cage filled with Trinity demineralized bone matrix was positioned with good alignment. The distraction was removed. A Midas-Rex was used to decompress the levels to decompress and expand the opening of the foramen.

We proceeded to the next level and incised the annulus at C4-C5. The content of the disk was removed. The ligament was removed and Midas-Rex was used to decompress the foraminal site. A cage of 5 mm was placed with demineralized bone matrix and trinity. The anterior plate from C4-C6 was placed with 6 screws obtaining good alignment under fluoroscopic guidance. The incision was closed with Vicryl 3-0 to the platysma and 4-0 Monocryl subcuticular. At the end of the procedure, the patient was extubated. He did present any neurological deficits. A soft collar was placed and he was sent to recovery.

Operative Report

LOCKLEAR, GARY - H-801304794

* Final Report *

If the report has been electronically signed, see completed action list below.

Lucia J Zamorano, MD
SIGNATURE OF SURGEON/DATE

D: 06/02/2009 08:06:47
T: 07/30/2009 16:01:36
MEDQ/Job #357973
Edited Date: 07/30/2009 s.rapnicki

Dictated by: Lucia J Zamorano, MD

Completed Action List:
* Perform by ZAMORANO MD, LUCIA J on 02 June 2009 08:06
* Transcribe by TRANSCRIPTION, MEDQUIST on 30 July 2009 16:01
* Sign by ZAMORANO MD, LUCIA J on 02 August 2009 17:34 02 August 2009 17:34
* Modify by ZAMORANO MD, LUCIA J on 02 August 2009 17:34
* VERIFY by ZAMORANO MD, LUCIA J on 02 August 2009 17:34

Surgical Procedure Note

LOCKLEAR, GARY - H-801304794

" Final Report "

Result type:	Surgical Procedure Note
Result date:	02 June 2009 18:45
Result status:	Auth (Verified)
Encounter info:	122229810, HARPER-HUTZEL, Inpatient-Discharged, 06/01/09 - 06/02/09

* Final Report *

Printed by: MAYS, DYNEISE
Printed on: 10/07/09 09:04

DMC
DETROIT MEDICAL CENTER

FIN: 122226810 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
/ / DOS:
PCP:
ATTN: ZAMORANO MD, LUCIA J

IMMEDIATE POST-OPERATIVE AND INVASIVE PROCEDURE NOTE

Pre-Operative/Procedure Diagnosis: C4-C5, C5-C6 Stenosis, Extruded Disc C5

Post-Operative/Procedure Diagnosis: Same

Operation/Procedure: - Anterior Cervical discectomy (discectomy) + fusion
- Arthrodesis
- Microsurgery / Microdissection & Decompression
- Fluoroscope Imaging

Primary Physician(s)/LIP: Dr. L. Zamorano

Assistant(s): ☐ NA Audrey Murray PAC

Urine: 750 cc

Estimated Blood Loss (EBL): < 50 ml

Fluids 1300 cc Crystalloid

Specimens Removed: ☐ NA C4-C5 + C5-C6 disc to Pathology

Drains: 0

Findings/Complications: 0

Anesthesia: GETA, Local, Marcaine ½% + Epi 10 cc

Condition: Extubated in stable condition to PACU

Other:

Signature: [signature] **Title:** PAC **Pager:** 93725 **Date:** 5-1-09 **Time:** 1:19 pm

Forms Mgmt Cmtee 11/08

DMC DETROIT MEDICAL CENTER

☐ CHM ☐ MBHS
☐ DRH ☐ RIM
☐ HTZ ☐ SGH
☐ HUH ☐ TCH
☐ HVSH ☐ DSH
☐ AMBULATORY

FIN: 122220610 PTID: 11122041
LOCKLEAR, GARY MRN: XXXXX4794
12/12/1950 M DOS: 06/01/09 06:00
HA – 4WS / 4407 / 02
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

Progress Notes

☐ Outpatient ☐ Inpatient

Date / Time	Record of Patient Progress (Please sign all entries with title designation)
6/3/09	Neurosurgery
[illegible]	- c/o neck pain – pain improved since surgery
Date/Time	- c/o headache
Date/Time	Awake Alert oriented x3
Date/Time	MAE (R) biceps/triceps 4/5 (L) UE 5/5
Date/Time	(+) commands (R) Deltoid 4/5
Date/Time	Speech fluent
Date/Time	Inc c/o [illegible]
Date/Time	A/P POD C4-5 C5-6 ACDF
Date/Time	- pain control
Date/Time	- ambulate
Date/Time	- d/c PCA
Date/Time	- d/c home
Date/Time	- d/w Dr Zamorano
Date/Time	Signed by: ZAMORANO ~~MD, LUCIA J~~ [signature] CNP 9960/5855
Date/Time	
6/3/09	[illegible] occupational therapy consult received [illegible]
Date/Time	[illegible] follow EMR forms. Thank you [illegible]
Date/Time	
Date/Time	
Date/Time	
Date/Time	
Date/Time	
Date/Time	
Date/Time	

S228607FPK (11/05)

DMC DETROIT MEDICAL CENTER

☐ CHM ☐ MBHS
☐ DRH ☐ RIM
☐ HTZ ☐ SGH
☐ HUH ☐ TCH
☐ HVSH ☐ DSH
☐ AMBULATORY

FIN: 122229610 PTID: 11122041
LOCKLEAR, GARY MRN: XXXXX4794
12/12/1950 M DOS: 06/01/09 06:00
HA - 4WS / 4407 / 02
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

Progress Notes

☐ Outpatient ☐ Inpatient

Date / Time	Record of Patient Progress (Please sign all entries with title designation)
Date/Time	D/c instructions given to patient and wife including
Date/Time	activity instructions, medications, referrals for
Date/Time	homecare, follow-up appointment instructions, and
Date/Time	signs and symptoms to watch for to notify
Date/Time	physician. Bothe verbalized understanding
Date/Time	of instructions and signed the form. A copy
Date/Time	of the instructions were given along with
Date/Time	the prescriptions. IV was removed, site had
Date/Time	no redness or swelling. Transportation picked
Date/Time	up patient in a wheelchair and he was
Date/Time	discharged with his wife and all of his
Date/Time	personal belongings.
Date/Time	DeBeche OCC SN
Date/Time	OMS note
Date/Time 6/2/09	Called pt's home to verify address
Date/Time 1649	for home care. Spoke to wife
Date/Time	Pamela Locklear 248-736-0458
Date/Time	and she informed me Mr Gary
Date/Time	Locklear does not want home
Date/Time	care. Informed Dr. David Hoang
Date/Time	5859. 10254
Date/Time	
Date/Time	
Date/Time	
Date/Time	

DMC
DETROIT MEDICAL CENTER

☐ CHM ☐ MBHS
☐ DRH ☐ RIM
☐ HTZ ☐ SGH
☐ HUH ☐ TCH
☐ HVSH ☐ DSH
☐ AMBULATORY

FIN: 122229610 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
/ / DOS:
PCP:
ATTN: ZAMORANO MD, LUCIA J

Progress Notes

☐ Outpatient ☐ Inpatient

Date / Time	Record of Patient Progress (Please sign all entries with title designation)
	Dictated #556765
	[signature] 3012 [illegible]

0225001FPK (11/08)

2009-10-08 14:19 OP 3-513 3135783965 >> 2488489506 P 14/23

DMC DETROIT MEDICAL CENTER WAYNE STATE UNIVERSITY

☐ CHM ☐ KCC ☐ DRH ☐ MSOH ☒ HUH ☐ RIM ☐ HVSH ☐ SGH ☐ HWH

035

FIN: 122229810 PTID: 11122041
LOCKLEAR, GARY MRN: XXXXX4794
12/12/1950 M DOS:
/ /
PCP:
ATTN: ZAMORANO MD, LUCIA J

HISTORY AND PHYSICAL

DATE 6-1-09

HISTORY

CHIEF COMPLAINT

Neck pain x7 1/yr

PRESENT ILLNESS

Pt is a 58 y/o Caucasian male c PMH HTN, Hypercholesterolemia, OSA, GERD and OA who presents to HUH for Anterior Cervical discectomy and fusion: C4-C5, C5-C6; c/o Neck pain x7/yr. Pt states he fell last year and severely injured his spine. He further state he had lower back surgery last July and realized how severe is neck pain was. Pt reports neck pain radiates to (R) shoulder and down (R) UE to the (R) 4th + 5th digits. Pain constant shooting; 10/10. Pt admits to (R) UE paresthesia, but denies HA, double vision, dizziness and weakness.

Wear glasses
Allergies: NKDA
Cell: cmb

MEDS: Vicodin, diazepam, Lipitor, Omeprazole, Micardis

Past surgeries

- Appy - 1970's
- Knee Arthroscopy - 1980's
- Lumbar laminectomy 7108
- UVulectomy - 1980's
- (L) Hand repair 10 "10's

PAST MEDICAL HISTORY (INCLUDE ANY MEDICATIONS / ALLERGIES)

Childhood / Adult Illness
Previous Surgery / Fractures (+) C4-C5, C6-C6 Disc Herniations

(+) Hyper Cholesterolemia
(+) HTN
(-) COPD
(+) OSA-CPAP
(+) GERD
(-) Thyroid d/z
(-) Heart d/z
(+) DM
(-) Anemia
(+) OA - back + Hands

FAMILY HISTORY

Hypertension, TB, Cancer, Heart Disease, Diabetes, Bleeding Disorder, Sickle Cell

Non Contrib

SOCIAL HISTORY (INCLUDE SEXUAL HISTORY)

Occupational, Travel, Tobacco, Alcohol, Drugs

(+) Tobacco: 1-1½ ppd x 30 years, Quit 2 weeks
(+) ETOH - social
(-) Recreation drug use

32258003 (10/05)

FIN: 122229610 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
HA – 4WS / 4407 / 02 DOS: 06/01/09 05:00
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

SYSTEM REVIEW
At least ten organ systems must be reviewed. Check POS or NEG for each system.
Use space below to document pertinent findings.

	POS	NEG		POS	NEG	
1.	☑	☐	CARDIO RESPIRATORY Dyspnea, Cough/Sputum, Palpitations, Asthma, Angina, Myocardial Infarction, ~~Hypertension~~, Chest Pain			
2.	☑	☐	GASTROINTESTINAL Nausea, Vomiting, Hemorrhoids, Jaundice Bowel Habits, Weight Change, Appetite			
3.	☐	☑	GENITOURINARY Frequency, Nocturia, Dysuria, Retention, Bleeding, Incontinence, Prostate Disease, Menstrual (History/Pregnancy)			
4.	☑	☐	MUSCULOSKELETAL Fracture, Deformity, Trauma			
5.	☑	☑	NEUROLOGICAL Headache, Dizziness, Fainting, Memory, CVA			
6.	☑	☑	~~EENT~~ Vision Glasses, Hearing, Tinnitus, Discharge, Lesions, Speech, Teeth, Sinus			
7.	☐	☐				INTEGUMENTARY (SKIN AND/OR BREAST) Color, Pigmentation, Eruptions, Pruritus, Hair, Nails
8.	☑	☐				PSYCHIATRIC Mental Status, Medications, Alcohol/Drugs
9.	☐	☐				ENDOCRINE Hair Distribution, Skin Pigmentation, Weakness, Polydipsia, Polyuria, Impotence, Sterility
10.	☐	☐				HEMATOLOGIC / LYMPHATIC /ONCOLOGIC Anemia, Lymphadenopathy, Bleeding, Enlargement, Pain
11.	☐	☐				ALLERGIC / IMMUNOLOGIC Dermatitis, Urticaria, Eczema, Hay Fever, Asthma, Migraine

DMC
DETROIT MEDICAL CENTER
WAYNE STATE UNIVERSITY

☐ CHM ☐ KCC
☐ DRH ☐ MISOH
☐ HUH ☐ RIM
☐ HVSH ☐ SGH
☐ HWH

FIN: 122229810 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
/ / DOS:
PCP:
ATTN: ZAMORANO MD, LUCIA J

HISTORY AND PHYSICAL

PHYSICAL EXAM
GENERAL Ht. _____ Wt. _____ T _____ Pulse _____ BP _____

Pt is a 58 y/o Caucasian male; Slightly anxious
Reporting slight neckpain

EARS / EYES / NOSE / THROAT / NECK

Eyes: PERRLA, EOMI, ~~OSC~~, ~~erythema~~
ENT: ~~OSC~~, ~~erythema~~
Neck: supple

HEART

RRR, S1+S2, ~~OM~~ M/r/g

THORAX / LUNGS

CTAB.

BREAST / LYMPH NODES

(-) lymphadenopathy

ABDOMEN

BSx4, ND, NT

GENITALIA / RECTAL

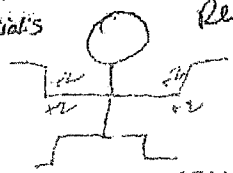
Deferred

BACK / EXTREMITIES

UE: Oedema (R): 3/5 (L) 4/5 Strength
LE Oedema Strength (R): 3/5 (L) 3/5
(-) pain upon palpation of Spine

NEUROLOGICAL

A+Ox3
CNII-CNXII; intact
(R) Hypoesthesia; (R) 4th + 5th digit
(-) Kurnig / Brudzinski
(+) Brachioradialis 2/4
(+) Triceps 2/4
Reflexes



2009-10-08 14:20 OP 3-513 3135783965 >> 2488489506 P 17/23

LAB

See EMR

REVIEW OF PREVIOUS MEDICAL RECORD

FIN: 122228810 PTID: 11122041
LOCKLEAR, GARY MRN: XXXXX4794
12/12/1950 M DOS: 06/01/09 05:00
HA - 4WS / 4407 / 02
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

See EMR

ASSESSMENT AND PLAN

(1) C4-C5 ; C5-C6 disc herniation c Paresthesia
Pt receiving

(2) HTN

(3) Hypercholesterolemia

(4) OSA

(5) GERD

(6) OA - hands + back

(7) Hx Tobacco smoking

Signature, Resident — Date/Time

Signed by: ZAMORANO MD, LUCIA J

Signature, Attending Physician — Date/Time

3 of 4

DMC DETROIT MEDICAL CENTER ☐CHM ☐KEI ☐DRH ☐RIM ☒HUH ☐SGH ☐HVSH ☐DSH ☐HWH

FIN: 122229910 PHD: 11122001
LOCKLEAR, GARY
12/12/1950 M
MRN: XXXXX4794
DOS:
POP:
ATTN: ZAMORANO MD, LUCIA J

ADULT-PREOP EVALUATION FORM / HISTORY & PHYSICAL

☐ VISIT ☐ TELEPHONE
Pre-Op/Pre-Test Call: Date: _____ Time: _____ Initial Contact Person: _____
Patient Name: _____ ☐ M ☐ F Telephone: Home: _____ Work: _____
Procedure: _____ Procedure Date: _____
Surgical Site verified ☐ Yes ☐ No; for paired organs/limbs ☐ Left ☐ Right autologous blood donor Y ☐ N ☐
Surgeon: _____ Preop Instructions Given To: ☐ Patient ☐ Family Member ☐ Other/Guardian _____
Allergies (Meds., Latex, Environ., Food) ☐ NONE ☐ YES ☐ PRESENT MEDICATIONS/OTC ☐ NA
Reaction? _____

NAME	DOSE	FREQUENCY	LAST DOSE	*

* MEDICATION INSTRUCTED TO TAKE WITH A SIP OF WATER

PAST SURGICAL HISTORY: ☐ NONE ☐ YES

AGE: _____ HEIGHT: _____ WEIGHT: _____ COULD YOU BE PREGNANT: ☐ YES ☐ NO LMP: _____ ☐ NA
LANGUAGE BARRIER: ☐ YES ☐ NO INTERPRETER: _____ PHONE#: _____
LEARNING BARRIER: _____ ARE YOU EXPERIENCING PAIN? ☐ YES ☐ NO
PAIN: VAS AT REST _____ VAS WITH ACTIVITY _____ LOCATION: _____ MGMT OF PAIN: _____
ARRIVAL TIME: _____ SURGERY TIME: _____ DRIVER/PHONE #: _____
ADULT SPENDING THE NIGHT POST SURGERY: _____ NPO TIME: ☐ MN ☐ OTHER: _____

☐ Leave valuables at home
☐ Wear loose, comfortable clothing
☐ Unable to operate a motor vehicle, machinery or power tools, or drink alcohol, or sign important papers 24 hours postop.
Physical Limitations ☐ Yes ☐ No

MEDICAL HISTORY: PLEASE CHECK EITHER YES, NO. IF THERE IS MORE THAN ONE CHOICE, CIRCLE THE ONE THAT PERTAINS.

MEDICAL HISTORY	YES	NO	MEDICAL HISTORY	YES	NO
Problems with anesthesia Pt./ Family			Hiatal Hernia/Ulcers/Gastritis/Reflux		
Bleeding/Clotting disorder			Diabetes		
High Blood Pressure/Stroke			Seizures/Epilepsy/Blackouts		
Heart Attack/Enlarged Heart/Congestive Heart Failure			Sciatica/Back Problems/Slipped Disc		
Rheumatic Fever/Heart Murmur/Mitral Valve Prolapse			Arthritis/Neck problems		
Chest Pain/Angina/Pacemaker			Kidney/Liver Disease		
Shortness of Breath/Cough/Pneumonia			Bladder/Prostate problems		
Bronchitis/Emphysema/Asthma			Anemia/Sickle Cell Disease		
Recent cold/sore throat			Thyroid Disease/Goiter		
Do you smoke: ppd for yrs/Quit yrs			History of street/social drug use		
Special weight loss diet/Meds			Drink alcohol - How much -		
Glaucoma/Other visual problems			Psychiatric History		
Recent exposure to any communicable diseases ☐ TB ☐ HIV ☐ STD's ☐ Hepatitis ☐ Other			Herbal Remedies Recent Labs/Tests/X-rays/Medical Visits:		
Aspirin/Anti-inflammatory use					
History of Cancer			Other:		

COMMENTS: _____

Signature/Title: _____ Date/Time: _____

3225/08J (4/04)

FIN: 122229810 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M
MRN: XXXXX4784
DOS:
PCP:
ATTN: ZAMORANO MD, LUCIA J

ANESTHESIA

Check Required Test: ☐ HGB/HCT ☐ CBC ☐ WBC ☐ FBS ☐ EKG ☐ CXR
☐ PREGNANCY TEST ☐ K ☐ Na ☐ LYTES ☐ ABG'S ☐ PT ☐ PTT
☐ BLEEDING TIME ☐ OTHER
Comments on Test Results:
Intravenous Therapy: LR ☐ 1000ml ☐ 500ml D5LR ☐ 1000ml ☐ 500ml D5W 0.45% NaCL ☐ 1000ml ☐ 500ml
NS ☐ 1000ml ☐ 500ml OTHER
Preop Med Orders:
ASA Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ E Teeth: ☐ Intact ☐ Loose ☐ Partials ☐ Dentures ☐ Crowns
Airway Assessment: (Based upon mallampati, neck extension, submental space, etc): ☐ I ☐ II ☐ III ☐ IV
Anesthesia Plan: ☐ General ☐ MAC ☐ Local ☐ Regional
Anesthesia Plan/Risks discussed with patient/guardian; patient understands/accepts ☐ Yes ☐ No If no, explain
Comments:
Signature/Title Date/Time

RE-EVALUATION (If above evaluation is not done immediately preoperatively)

Changes since initial evaluation: Yes ____ No ____ If yes, explain
Signature/Title Date/Time

PHYSICAL EXAMINATION

Present Illness/Indication for Surgery:
History Reviewed: ☐ Yes Comments:
Blood Pressure: Pulse: Respirations: Temperature:
HEENT: ☐ Normal LUNGS: ☐ Normal
HEART: ☐ Normal ABDOMEN: ☐ Normal
MENTAL STATUS: ☐ Alert and Oriented ☐ Other:
PELVIC: ☐ Yes ☐ No EXTREMITIES: ☐ Normal
Physical Findings:
Preop Diagnosis:
Plan/Proposed Surgery:
History and Physical Dictated: ☐ Yes ☐ No
Signature/Title: Date/Time:

DMC
DETROIT MEDICAL CENTER

☐ CHM ☐ RIM
☐ DRH ☐ SGH
☐ HWH ☐ WOSH
☐ HUH
☐ HVSH

028

FIN: 122229610 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
HA – 4WS / 4407 / 02 DOS: 08/01/09 06:00
PCP: KARACSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

ADULT PATIENT DISCHARGE INSTRUCTION RECORD:

Discharge Date 8/2/09

Appointments and Plan for Continued Care:

Physician/Clinic Dr Zamorano Date 1-2 wks Phone 248-203-2477
Physician/Clinic _____ Date _____ Phone _____
Physician/Clinic _____ Date _____ Phone _____
Laboratory/Other tests _____
Comments: _____

ACTIVITIES: Resume usual activities unless otherwise indicated

Limitations:

☐ Stop any activity at the first sign of chest pain, heaviness or tightness or increased shortness of breath.
☐ Alternate activity periods with rest periods; breakup large activities into smaller tasks
☐ No driving until after first follow-up visit with physician
☐ No work/school until first follow-up with physician
☐ No lifting
☐ Avoid sexual activity until after first follow-up visit with physician
☐ No bending/twisting at waist
☐ Other _____

DIET: No dietary restrictions unless otherwise indicated

☐ Low Sodium ☐ Low Cholesterol ☐ Renal_____ ☐ Diabetic ADA _____ calories ☐ Other_____
☐ Special Instructions _____

SPECIAL INSTRUCTIONS OR TREATMENT:

May shower – no bathing

PERSONAL RISK FACTORS:

a. Tobacco Use: ☐ No ☐ Yes ☐ Smoking counseling provided ☐ Medication prescribed _____
b. Pneumococcal Vaccine: ☐ Yes Date: _____ ☐ Refused/contraindicated
c. Influenza Vaccine (Oct. - March): ☐ Yes Date: _____ ☐ Refused/contraindicated
d. My Total Cholesterol (TC) = _____ (Goal less than 200) Low Density Cholesterol (LDL) = _____ (Goal less than 100)
High Density Cholesterol (HDL) = _____ (Goal greater than 40)
e. Heart Function Ejection Fraction (EF) _____%

Notify Physician Immediately for any of the following symptoms:

- **Call 911 if you have sudden chest pain unrelieved by medication, lasting longer than 15 minutes or**
- **Call 911 if shortness of breath.**
- If you have heaviness in the chest, palpitations, lightheadedness, weakness, sweaty or nausea
- If you are on blood thinners and you start to bleed in your urine, stool or from nose or gums
- If you have sudden weight gain
- If you have increased swelling in your ankles, legs or stomach/abdomen
- If you have a fever above 100.4 or _____
- If your pain medication is no longer working
- Other: _____

IF YOU HAVE ANY FURTHER QUESTIONS, CONTACT YOUR PHYSICIAN OR CLINIC

FIN: 122228810 FTID: 111122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4794
HA ~ 4WS / 4407 / 02 DOS: 06/01/09 06:00
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

Discharge Planner to complete this section:

REFERRALS FOR CONTINUED CARE:

☑ Home Care Agency/Phone Prime Care 248-967-8572 Date of 1st visit _____

☐ Equipment Supplier/Phone _____ Delivery Date _____

DMC REFERRAL SERVICES 1-888 DMC 2500 (1-888-362-2500)

☐ Site: _____ Smoking Cessation Program _____

☐ Site: _____ Diabetic Education Program _____

☐ Site: _____ Cardiac Rehab Resources _____

☐ Site: _____ Nurse Triage Heart Support _____

☐ Other _____

RN TO COMPLETE THIS SECTION

Written Health Care Resources provided: (check those that apply):

Health Maintenance Agreement: ☐ Heart Failure ☐ Myocardial Infarction/Acute Coronary Syndrome

Other Specific Educational Resource: _____

Additional Education Provided: For more information call 1-888-DMC-2500

☐ Smoking Cessation ☐ Weight Monitoring ☐ Implantable Electronic Device (IED) Type _____

☐ Medications ☐ Worsening signs and symptoms

☐ Diet ☐ Pain Management

☐ Cholesterol Guidelines ☐ Food/Drug Interactions

☐ Exercise ☐ Implantable Cardiac Device/Biventricular

☐ Pacing book and card ☐ Other: _____

Physician Signature _____ **Date/Time** 6/2/09

I have received and understand my discharge instructions:

X _____ Date 6/2/09

Signature of patient or responsible party (Parent or guardian if patient is a minor)

DISCHARGE STATUS

Discharged to: ☒ Home ☐ Other: _____

Accompanied by: _____

If patient is minor, identity of parent/guardian is verified ☐ Yes

_____ Date/Time 6/2/09

Signature of RN Completing Discharge

Please bring a copy of this instruction sheet with you to your physician on your follow up visit

Patient Discharge Instruction: Discharge Medications

FIN: 122228610 PTID: 11122041
LOCKLEAR, GARY
12/12/1950 M MRN: XXXXX4704
HA – 4WS / 4407 / 02 DOS: 06/01/09 06:00
PCP: KARADSHEH, KHALIL M
ATTN: ZAMORANO MD, LUCIA J

Discharge Date _____

Allergies:

Order the following medications for:
Heart Failure: Aspirin, ACEI/ARB, Beta Blocker, Diuretic
Acute Myocardial Infarction: Aspirin, Beta Blocker, ACEI/ARB, Statin, and Clopidogrel
If not on these medications, document reason below.

Allergy/contraindication: **DO NOT TAKE** - state reason for not taking any of the following drugs:

☐ Aspirin _____ ☐ Beta Blocker _____
☐ ACEI _____ ☐ Statin _____
☐ ARB _____

When to Take your Medication			
Daily	1 time a day	QID	4 times a day
BID	2 times a day	PRN	As needed
TID	3 times a day	HS	At bedtime

How to Take your Medication					
PO	By Mouth	TF	Tube Feeding	SL	Under the tongue
IM	Into the muscle	GT	Gastric Tube	Sub Q	Under the skin, into fatty layer
IV	Intravenous	PR	Per Rectum		

Medication Name *Include all home medications continued on discharge plus ANY NEW prescription medications, OTC, herbals, etc. Include name, dose/concentration, route, frequency and time/date next dose due.*	**Reason for Medication**	**Next Dose Due**
Continue taking these home medications:		
Micardis HCT 40 mg daily	BP	6/3/09
Omeprazole 20mg bid	stomach/ulcer	6/3/09
Lipitor 20mg Daily	cholesterol	6/3/09
Valium 5mg po q6h prn	anxiety	6/2/09
New medications:		
Norco 7.5/325 one tab q4h prn	pain	3pm 6/2/09
Colace	stool softener	6pm 6/2/09

Stop Taking These Medications *Include name, dose/concentration, route, frequency*	**Reason**
Valium 5mg po q6h prn	
Celebrex	

Exhibit 12

HealthStyles PHYSICAL REHABILITATION
301 S. Lafayette • South Lyon, MI 48178 • (248) 486-0 • Fax (248) 486-3318
12420 Grand River Suite B • Brighton, MI 48116 • (810) 229-3022
www.healthstylesrehab.com

Patient Name: Gary Locklear
History/Diagnosis: Low Back Pain
Precautions/X-rays: Cervical fusion 04/04, Lumbar laminectomy 7/05
Frequency/Duration: ____5X/WK ____3X/WK ____2X/WK For____WKS

PHYSICAL THERAPY PRESCRIPTION
OCCUPATIONAL THERAPY PRESCRIPTION
SPEECH THERAPY PRESCRIPTION

FAXED 9/29/09 LZ

- ✓ P. T. Eval. & Treatment
- ___ O. T. Eval. & Treatment
- ___ Speech Eval. & Treat.
- ___ Posture Eval. & Instruction
- ___ Aquatic Therapy
- ___ Hand Therapy
- ___ Lymphedema Program
- ___ Back School
- ___ Stroke Rehab
- ___ Neuromuscular Re-education
- ___ Health Styles Fitness Center Referral
- ___ Heat Packs/Ice Packs
- ___ Paraffin Bath
- ___ Electrical Stimulation
- ___ Whirlpool
- ___ Traction (Cervical/Lumbar)
- ___ Therapeutic Massage
- ___ Myofascial Release
- ___ Ultrasound
- ___ Phonophoresis
- ___ Iontophoresis
- ___ Other
- ___ Therapeutic Exercise
- ___ Passive R.O.M. Exercise
- ___ Active R.O.M. Exercise
- ___ Active Assisted Exercise
- ___ Progressive Resistive Exercise
- ___ Mobilization Exercise
- ___ T.E.N.S.
- ___ Gait Training
- ___ Home Exercise Instruction

PHYSICIAN'S SIGNATURE [signature] DATE 9/29/09
Lucia Zamorano, MD

Oct 02 2009 9:42AM 248-481-3913 p.2
Oct. 1. 2009 12:52PM ..alth Styles Rehabilitation No. 7267 P. 2

HealthStyles
PHYSICAL REHABILITATION

301 S. Lafayette South Lyon, MI 48178
(248) 486-1110 Fax (248) 486-3318
12420 Grand River, Suite B Brighton, MI 48116
(810) 229-3022 Fax (248) 486-3318

PLAN OF CARE

PATIENT NAME: Gary Locklear DOB: 12/12/50

DIAGNOSIS: LBP, post laminectomy syndrome

PRECAUTIONS/TESTS: cervical fusion 6/09

MEDICAL HISTORY: work injuries
(If significant)

SERVICE: ✓ PT ___ OT ___ SOCIAL WORK ___ SPEECH THERAPY

PLAN OF TREATMENT:
1) MHP/IFC to paraspinals Lumbar 15' supine
2) US x 8' 1.5 w/cm² applied as above
3) TE to ↑ posture flexibility, core strength 30-45'
4)
5)
6) Aquatics 1-2x for ↑ flexibility / strength, bal

GOALS:

STG:
1) ↓ pain 50% in LB
2) ed able to stand upright ___ effort
3)
4) able to sit in/outer bed
5) ↓ sleep ___ difficulty
6) able to roll in bed ___ get out of chair

LTG:
1) only min. diff. ē gait
2) ___ recovering ___ a.m.
3)
4) comm. distance ___ pace tol'd
5) 20'
6) ↑ Back ROM by 10°, Forv to knee

THIS PATIENT WILL BE SEEN 3 TIMES PER WEEK FOR 4 WEEKS.

I CERTIFY ✓ RECERTIFY ___, THAT I HAVE EXAMINED THE PATIENT AND PHYSICAL THERAPY AND/OR OCCUPATIONAL THERAPY AND/OR SOCIAL SERVICES AND/OR SPEECH THERAPY IS NECESSARY AND THAT THESE SERVICES WILL BE PROVIDED WHILE THE PATIENT IS UNDER MY CARE. THE ABOVE PLAN OF CARE IS ESTABLISHED AND WILL BE REVIEWED EVERY 30 DAYS. I ESTIMATE THAT THESE SERVICES WILL BE NEEDED FOR 30 DAYS, AND BELIEVE THAT PATIENT'S REHABILITATION POTENTIAL IS ___. BY SIGNING THIS PLAN OF CARE, AUTHORIZATION IS GIVEN FOR THE ABOVE TREATMENT EFFECTIVE DATE OF INITIAL EVALUATION AND/OR DATE OF RECERTIFICATION 10-1-9 BY ___
DATE PHYSICIAN SIGNATURE

PHYSICIAN NAME: Lucia Zamarano MD

THERAPIST SIGNATURE: [signature] PT

318.19

NOV. 10. 2009 9:14AM RITEWAY TRANSPORT NO. 457 P. 14

HealthStyles
PHYSICAL REHABILITATION
Physical • Occupational • Speech Therapy
Barbara Herzog, P.T.
301 S. Lafayette
South Lyon, MI 48178
(248) 486-1110

12420 Grand River
Suite B
Brighton, MI 48116
(810) 229-3022

EVALUATION

DATE:10/01/09
PATIENT NAME:Gary Locklear
PHYSICIAN NAME:Lucia Zamorino ,MD
DIAGNOSIS:LBP
DOB:12/12/50

DATA-BASE: This patient has complaints of high pain level in low back that has been present for some time, he feels the back pain is limiting him more than his recent cervical fusion surgery. He felt good results in neck pain since surgery and rehabilitation of cervical fusion. Major complaint is of getting out of bed, getting out of lying position , walking , stairs and Adl's , putting on shoes , socks and pants are difficult and painful.
Currently taking the following medications , muscle relaxor 5mg. , vicoden 750mg. 1 tab by mouth . He has been off work since May 7 2009 , has been unable to return to work.

S:This patient is a 58 year old male with pain resulting from work related injuries and surgeries . Currently low back pain is most limiting and does not allow him to dress , walk , sleep , stairs , take care of yard or house without significant pain and difficulty. Prior level of function working full time . Independant in household chores and yardwork.

O: Posture observed forward flexed and guarded , difficult to move in and out of positions, laying , seated , standing .
+ tenderness and increased muscle tone palpated paraspinal. Observed 2 inch laminectomy scar central L4L5 , tenderness and adhesions present.
ROM flexion lumbar spine 40° , extension -15° , RSB -9°, LSB 18° , (+) SLR test bilateral , flexibility decreased pelvic region and thigh .

Treatment Today: MHP/IFC x 15 minutes , US x 8 minutes to lumbar paraspinals 1.5 cW/cm2 , AROM , Nustep , stretches from standing .
A:Rehabilitation potential is guarded , secondary to other conditions . Short term goals : decrease pain 50% in back , enable to stand upright without effort, able to get in/out of bed and sleep with minimal difficulty, able to roll in bed and get out of chair. Long term goals : only minimal difficulty with gait , less recovery time in mornings , community distance and pace tolerated , increased back ROM by 10° , forward flexion reach fingers to knees.

P:This patient will be seen in physical therapy three times per week for four weeks, we will utilize moist heat / IFC x 15 minutes , ultrasound x 8 minutes @ 1.5 c W/cm2 , Therapeutic exercise program for strengthening , flexibility , aquatic exercises for increase of ROM tolerance .

Thank you for your referral.

Tamela Valencia, P.T.

FAXED

HealthStyles
PHYSICAL REHABILITATION

Hockley, Gary
PATIENT NAME & CHART NUMBER

1 Unit = 8 to 22 mins.
2 Units = 23 to 37 mins
3 Units = 38 to 52 mins
4 Units = 53 to 67 mins
5 Units = 68 to 82 mins
6 Units = 83 to 97 mins

DATE	CODE	UNITS	LB Book
9/1/09	97001	1	IE today. Extremely guarded
	97010	1	movements, unable to stand upright.
	97014	1 IFC	Began c MHP/IFC to ↓ pain 15' in
	97035	1	supine. US x 8' 1.8 w/cm² L-paraspinals
	97110	1	from massage chair. TE for
			stretching & gentle strengthening 15'
			[illegible]

DATE	CODE	UNITS	
10/6/09	97113	4	[illegible] nerve dmg. @ LE. neck (LBP) Rt ROT.
			obj: [illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible]

DATE	CODE	UNITS	
10/7/09	97010	1	S: no major Δ's to LBP since starting PT for LB.
	97014	1	O: MHP c IFC L spine (sealed). US x 8' 1.5 w/cm² lumbar
	97035	1	Region in sitting. TE x 30' to focus on lumbar stability. Scar tissue mob/MFR 15'
	97140	1	A: Pt did fair well. Pt had some relief of [illegible]
	97110	1	c stretches. Still TTP over scar region.
			P: Cont to advance per POC [illegible]

Exhibit 13

Oakland MRI

5119 Rochester Road
Troy, Michigan 48085

www.oaklandmri.net

Phone 248.740.0777
Fax 248.740.9777
888.MRIMRAS (674.6727)

All Physicians certified by the American Board of Radiology

PATIENT NAME: LOCKLEAR, GARY
DATE OF BIRTH: 12-12-50
DATE OF EXAMINATION: 8-12-10
REFERRING PHYSICIAN: Dr. Zamorano

Clinical Information: Lumbar disc disease, rule out instability.

Comparison: None.

LUMBAR SPINE X-RAY SEVEN VIEWS:

Flexion and extension lateral views are included.

There is multilevel disc space narrowing and vertebral endplate sclerotic change greatest so at L5-S1. There are facet changes posteriorly at L4-L5 and L5-S1 with grade I anterolisthesis of L4 on L5. There is, however, no change in vertebral body alignment with flexion and extension maneuvers.

IMPRESSION:
1. Grade I anterolisthesis of L4 on L5 without plain film evidence for dynamic subluxation.
2. Multilevel disc space narrowing and facet changes posteriorly lower lumbosacral spine greatest changes at L5-S1.

Anthony A. Bennett, M.D.
AAB/bgg.BZD
DT: 8-13-10

Exhibit 14

MICHI .N BRAIN & SPINE SUR(. .Y CENTER
LUCIA ZAMORANO, MD, PLC
Neurological Surgery
2004 Hazel Street. Birmingham, MI 48009
Tel: 248.723.2477 • Fax: 248.681.3209
http: www.luciazamorano.com

- *Neurosurgical Oncology (Gliomas, Meningiomas,*
- *Acoustic Neuromas,*
- *Pituitary Tumors)*
- *Stereotactic Surgery*
- *Computer Assisted Surgery*
- *Gammaknife*
- *Radiosurgery*
- *Vascular Malformations*
- *Epilepsy Surgery*
- *Trigeminal Neuralgia*
- *Minimally Invasive Surgery*
- *Endoscopy*
- *Pain Surgery*
- *Robotics*
- *Movement Disorders*
- *Cervical, Lumbar Spine Surgery*
- *Kyphoplasty*

With Offices Located at:

2004 Hazel Street
Birmingham, MI 48009
248-723-2477

Neurosurgery Group
43650 Garfield Road
Clinton Township
MI 48038
248-723-2477

Harper Professional Building
4160 John R. Ste. 730
Detroit, MI 48201
248-723-2477

5107 Rochester Road
Troy, MI 48085

Administrative Office
2708 Saint Joseph
West Bloomfield, MI 48324
Tel: 248-481-3617
Fax: 248-481-3913

September 17, 2010

Khalil Karadsheh, MD
30701 Woodward
Royal Oak, MI 48073

RE: **LOCKLEAR, GARY**

MRN: 371-52-4131

DATE OF BIRTH: December 12, 1950

Dear Dr. Karadsheh:

I had the pleasure of seeing your patient, Gary Locklear, in my outpatient office today for a follow-up appointment. Enclosed are my findings.

CHIEF COMPLAINT: The patient was involved in a work related accident in 2008 and complains of continuing lumbar pain.

HISTORY OF PRESENTING ILLNESS: The patient was involved in a work related accident in 2008. He underwent laminectomy with lateral recess and foraminal decompression of L4-L5, and laminotomy with discectomy per Dr. Eeric Truumees in 2008. The patient states that the surgery did not relieve his symptoms and he continues to experience lumbar pain. The patient also underwent anterior cervical discectomy and fusion of C4-C5 and C5-C6 in 2009. The patient presents today with continuing lumbar pain. He rates his lumbar pain as a 5/10, which increases to 7/10 with activity. He is one-week status post rotator cuff repair surgery. The patient complains of bilateral lower extremity pain and paresthesias equal on both sides.

PHYSICAL EXAMINATION:
GENERAL: The patient is in good general condition.
VITAL SIGNS: Height 6 feet 1 inch, weight 239 pounds, blood pressure 134/79, and pulse is 62.

The remainder of the physical and neurological examination is intact and unchanged from the prior visit.

MEDICAL DIAGNOSTICS: There are no new medical diagnostic studies.

ASSESSMENT: The patient was involved in a work related injury in 2008 and is now status post left hemilaminectomy defect at L4-L5 with continuing lumbar pain secondary to irregular facet changes and disk bulging at L4-L5. The patient is also status post anterior cervical discectomy and fusion of C4-C5 and C5-C6 with mild cervical pain.

MEDICAL DECISION MAKING AND PLAN: The patient was involved in a work related injury in 2008 and complains of lumbar and cervical pain. The patient's medications of Norco, Soma, Neurontin, and Ambien were refilled to manage his pain symptoms. The patient was instructed to continue wearing his lumbar brace for additional stability. The patient is not interested in surgical treatment at this time. He was encouraged to contact our office with any questions or concerns about his care.

Thank you again for entrusting me with the care of your patient.

Yours truly,

Lucia Zamorano, M.D.
Lindsay Gietzen, PA-C

cc: Eeric Truumees, MD
26025 Lahser
Southfield, MI 48033

FCS Industries
Adjuster, Bridget Green
Claim#: 440760
9850 Pelham Rd.
Taylor, MI 48180

Exhibit 15

All Notes

D/C Summaries signed by David M Montgomery, MD at 12/09/11 1544

Author: Nathan A Rimmke, MD Service: (none) Author Type: Physician
Filed: 12/09/11 1544 Note Time: 12/08/11 1701

ATTENDING PHYSICIAN: David M Montgomery, MD

DATE OF ADMISSION: 11/22/2011
DATE OF DISCHARGE: 11/29/2011

ADMISSION DIAGNOSIS:
Spinal stenosis with spondylolisthesis post laminectomy syndrome.

DISCHARGE DIAGNOSIS:
Spinal stenosis with spondylolisthesis post laminectomy syndrome.

HOSPITAL COURSE: This 60-year-old male underwent right-sided decompression with fusion and instrumentation L4-S1. Procedure was noncomplicated. The patient was admitted to the floor for pain control, physical therapy. Hospital course noncomplicated. Discharged in stable condition.

Medication list from oneChart discharge medication reconciliation as of 12/9/2011

Discharge Medication List as of 11/29/11 03:20 PM

START taking these medications

oxycoDONE (ROXICODONE) 5 MG PO Tab
take 1 Tab by mouth every 3 hours as needed for FOR MODERATE PAIN., Disp-50 Tab, R-0, Print

hydrocodone-acetaminophen (LORTAB) 10-500 MG PO Tab
take 1-2 Tabs by mouth every 3 hours as needed for FOR MODERATE PAIN., Disp-60 Tab, R-0, Print

docusate (COLACE) 100 MG PO Cap
take 1 Cap by mouth twice daily., Disp-60 Cap, R-0, Print

gabapentin (NEURONTIN) 300 MG PO Cap
take 1 Cap by mouth every 8 hours., Disp-90 Cap, R-0, Print

CONTINUE these home/prior to admission medications which have NOT CHANGED

lorazepam (ATIVAN) 1 MG PO Tab
take 1 mg by mouth every 12 hours as needed., Historical Med

MetFORMIN HCl (GLUCOPHAGE) 1000 MG PO Tab
take 1,000 mg by mouth PC BRKFST & DINNER., Historical Med

losartan-hctz (HYZAAR) 50-12.5 MG PO Tab
take 1 Tab by mouth once daily., Historical Med

simvastatin (ZOCOR) 40 MG PO Tab
take 40 mg by mouth once every morning., Historical Med

therapeutic multivitamin (MULTIVITAMINS) PO Tab
take 1 Tab by mouth once daily., Historical Med

omeprazole (PRILOSEC) 20 MG PO CAPSULE DELAYED RELEASE
take 20 mg by mouth as needed., Historical Med

STOP taking these home/prior to admission medications

Hydrocodone-Acetaminophen (LORCET) 10-650 MG PO Tab
Comments:
Reason for Stopping:

Nsg Discharge Note signed by Kathy J Zuk, RN at 11/29/11 1550

Author: Kathy J Zuk, RN Service: (none) Author Type: Registered Nurse
Filed: 11/29/11 1550 Note Time: 11/29/11 1545

A&O X3. VSS. Back dsg c/d/i. Toes warm, mobile. + pulses. Denies numbness, tingling. Pain well controlled with PO meds. Pt states "shooting pains down rt leg improved.". Ambulating in halls with walker. Slow, steady pace. Urinating adequate amt clear, yellow urine without difficulty. Bs + X4. LBM 11/28/11. Lungs CTA. Incentive spirometer encouraged with correct return demonstration. IV d/c'd. D/C to home. Instructions and scripts given. Verbalized understanding. D/C to home via WC with all personal belongings and family at side.

PT/OT Progress Note signed by Joanna Hadsell at 11/29/11 1533

Author: Joanna Hadsell Service: (none) Author Type: Physical Therapist
Filed: 11/29/11 1533 Note Time: 11/29/11 1407
Related Notes: Original Note by: Jennifer Couto filed at 11/29/11 1415

PHYSICAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 6 Rx Start time: 1330 Total Treatment Time 23 min. Room Number: 9491/92/9491

Discharge Recs: Home with assistance PRN, Outpatient PT
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity

ASSESSMENT (Summary of Findings): Patient tolerated therapy session good. Patient presents with difficulty performing functional activities/mobility due to radicular symptoms- LE weakness and ROM however improving . Patient is progressing well.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Logrolling bed mobility	Not assessed	not assessed
Transfers: sidely ↔ sit	Not assessed	not assessed

Transfers: sit ↔ stand	Supervision or setup	instructed to push off of bed/armrests and with assistive device
Gait:	Supervision or setup	150 feet x 2 with Rolling Walker, Full weightbearing bilateral UE's and LE's, Decreased step length and Step to
Brace management	Not appropriate	
Stairs:	Supervision or setup	Number of steps: 3 and Step to

PLAN:
Continue PT until goals achieved. Next treatment session will address:
- Bed Mobility
- Transfers
- Gait Training
- Stairs
- Education regarding precautions

SUBJECTIVE: " I think I am ready to go home"
Patient agrees to physical therapy treatment

OBJECTIVE:
Pt/family educated on role of Physical Therapy

Pain:
At Rest: 1 /10
With Activity: 2 /10 Per pt " there is always pain but improving overall"
Patient's pain goal: 0 /10
Location: LB Quality: aching

Pain management techniques:
RN Notified
Repositioning
Mobility/Exercise
Deep Breathing

Observation:
Up in chair before treatment

BALANCE STATUS	STATIC	DYNAMIC
Sitting	Good	Good
Standing	Good, With assistive device	Fair+, With assistive device

ADDITIONAL TREATMENT PROVIDED: gait training w/ stair ambulation and pt education
Endurance: Tolerated well

PATIENT EDUCATION:
Instructed patient / family on:
- Spinal precautions including no bending, lifting, twisting; no pulling/pushing
- Using brace when out of bed and proper application
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Stairs

Pt / family verbalized / demo good understanding of educational interventions

Interdisciplinary Communication: Spoke with continuing care regarding discharge plan

After therapy: Nursing aware of current status
Call light within reach - tubes and lines intact

Signature: Jennifer Couto, PTA 56728/ Joanna Hadsell, MPT

Previous Versions
11/29/11 1415 PT/OT Progress Note Signed By Jennifer Couto

Care Management signed by Lisa R George at 11/29/11 1424

Author:	Lisa R George	Service:	(none)	Author Type:	Social Worker
Filed:	11/29/11 1424	Note Time:	11/29/11 1420		

PT recs RW which per notes pt has & home with assist PRN. Wife to pick up at discharge.Pt agreeable. LGeorge LMSW 59169

OR Surgeon signed by David M Montgomery, MD at 11/29/11 0734

Author:	David M Montgomery, MD	Service:	(none)	Author Type:	Physician
Filed:	11/29/11 0734	Note Time:	11/22/11 1235		

PROCEDURE DATE: 11/22/2011

SURGEON: David M Montgomery, MD.
ANESTHESIA: General.

PREOPERATIVE DIAGNOSES:
1. Spinal stenosis.
2. Spondylolisthesis.
3. Postlaminectomy syndrome.

POSTOPERATIVE DIAGNOSES:
1. Spinal stenosis.
2. Spondylolisthesis.
3. Postlaminectomy syndrome.

OPERATION:
Right-sided transpedicular nerve root decompression L4, L5 and S1; bilateral lateral fusion L4, L5, S1; bilateral Xia instrumentation L4, L5 and S1; right-sided transforaminal lumbar interbody fusion L4-5, L5-S1 with AVS cages; local bone graft, bone marrow aspiration and Vitoss bone graft substitute.

FLUIDS: Crystalloid.

INDICATIONS: Gary Locklear has had previous surgery on his back. He has had persistent back pain and recurrent right lower extremity pain to the ankle with ankle dorsiflexion weakness. His symptoms have been unresponsive to extensive long-term conservative management. Workup showed foraminal stenosis and spondylolisthesis. He failed conservative treatment and was unwilling to live with the pain. He was aware of operative and nonoperative options. He was aware of potential problems and complications including, but not limited to bleeding, infection, injury to the nerves, paralysis, incomplete resolution of pain, failure of the fusion, failure of the implants, possible need to remove the implants, medical problems and complications, DVT, myocardial infarction, stroke, death, etc. He understood all this. He understood there were no guarantees and he wanted to proceed with the surgery.

PROCEDURE: The patient was taken to the operating room and administered a general anesthetic. He was placed in a prone position on the Jackson frame. Care was taken to pad all bony prominences. Prophylactic IV antibiotics were administered. TED hose and pneumatic stockings were in place. The low back was prepped and draped in a sterile fashion.

I made a linear incision through the previous scar and then stripped the muscles off the posterior elements of the spine to the tips of the transverse processes from L4 to S1 where there had been a previous laminectomy. I then used a curette to develop a plane between the scar and surrounding bone. I removed the inferior facet, pars and articularis of L4 and L5. I then did a transpedicular nerve root decompression out into the foraminal and extraforaminal area to completely unroof and free up the L4 and L5 roots. I also did a wide right-sided foraminotomy of the S1 root. I then instrumented the spine using a burr to create a hole at the junction of the transverse process and facet joint. I inserted a pedicle finder, followed by a pedicle probe. I could palpate cortical bone on all 4 inner walls of the pedicle. I inserted a tap, followed by Xia screws. Screws were inserted into L4, L5 and S1 on both sides of the spine. I could palpate the medial and inferior walls of the pedicles and there was no breach of the cortex.

I then exposed the disc at L5-S1. I made a wide box incision in the annulus and did a radical resection of the disc, along with the cartilage endplates. I packed the disc space with local autogenous graft and then inserted a 10-mm height AVS interbody cage packed with bone graft. I repeated the procedure at the L4-5 level. I packed the interspace with local autogenous bone graft and then inserted a 13-mm height AVS interbody cage. The PA and lateral views with the C-arm showed excellent position of the implants. I then irrigated the wound with pulsatile lavage irrigation system using antibiotic irrigant. I decorticated the spine from L4 to S1. I attached rods bilaterally and locked the rods into position along with a crosslink.

I packed an abundant amount of local autogenous graft over the transverse processes and facet joints. I mixed this with Vitoss bone marrow substitute, along with bone marrow aspirate obtained with a Jamshidi needle. I checked the roots again and they were completely free. I obtained hemostasis and then closed the fascia with #0 Vicryl over a Hemovac drain. Subcutaneous tissue was closed with 2-0 Vicryl and the skin with 4-0 Monocryl sutures. Sterile dressings were applied. The patient was then taken to the recovery room in stable condition.

Nsg Progress Note signed by Gayle McMillan, RN at 11/28/11 2310

Author: Gayle McMillan, RN Service: (none) Author Type: Registered Nurse
Filed: 11/28/11 2310 Note Time: 11/28/11 2246

NURSING PLAN OF CARE NOTE
See Active Problem List:

PROBLEM(S):

Pain r/t: DLL INTERVENTIONS: Medicated with Percocet and Roxicodone as needed. EVALUATION: Stable
Alt. Mobility: r/t: DLL INTERVENTIONS:Pt using rolling walker to assist with ambulation; Pt reminded to call for assistance with transfers. EVALUATION: Stable
Skin Integrity: r/t: DLL INTERVENTIONS: Monitor incision line for s/s of infection EVALUATION: Stable
Neurovascular: r/t DLL INTERVENTIONS: Assess neurovascular status q 4hrs; make sure pt has tht and pcd's. Pt skin clean and dry, + pedal pulses, capillary refill brisk. EVALUATION: Stable

Gayle McMillan , 11/28/2011 10:46 PM

PT/OT Progress Note signed by Marisa Balagtas at 11/28/11 1647

Author: Marisa Balagtas Service: (none) Author Type: Physical Therapist
Filed: 11/28/11 1647 Note Time: 11/28/11 1457
Related Notes: Original Note by: Jennifer Couto filed at 11/28/11 1509

PHYSICAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 5 Rx Start time: 1430 Total Treatment Time 25 mins Rm Number: 9491/92/9491

Discharge Recs: Subacute Rehab
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity

ASSESSMENT (Summary of Findings): Patient tolerated therapy session well. Patient presents with difficulty performing functional activities/mobility due to weakness, decreased ROM, decreased endurance and pain. Patient is progressing well.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Logrolling bed mobility	Supervision or setup	from sidelying and verbal cues
Transfers: sidely ↔ sit	Supervision or setup	logroll/sidelying, verbal cues and head of bed elevated
Transfers: sit ↔ stand	Minimal assistance	instructed to push off of bed/armrests, verbal cues, manual cues and with assistive device
Gait:	Minimal assistance	60feet with Rolling Walker, Full weightbearing bilateral UE's and LE's, Decreased step length, Slow and Step to
Brace management	Not assessed	
Stairs:	Not assessed	Not safe to practice stairs at this time

PLAN:
Continue PT until goals achieved. Next treatment session will address:
- Bed Mobility
- Transfers
- Gait Training
- Stairs
- Education regarding precautions

SUBJECTIVE: Pt seen b/s pt was sitting at EOB visiting with wife, willing to participate with PT
Patient agrees to physical therapy treatment

OBJECTIVE:
Pt/family educated on role of Physical Therapy

Pain:
At Rest: 5 /10

With Activity: 6- /10
Patient's pain goal: 0 /10
Location: LB Quality: aching

Pain management techniques:
RN Notified
Repositioning
Mobility/Exercise
Deep Breathing

Observation:
Up in chair before treatment

BALANCE STATUS	STATIC	DYNAMIC
Sitting	Good	Good
Standing	Good, With assistive device	Fair+, With assistive device

ADDITIONAL TREATMENT PROVIDED: TE, gait training, bed mobility and pt education
Endurance: Tolerated well

PATIENT EDUCATION:
Instructed patient / family on:

- Spinal precautions including no bending, lifting, twisting; no pulling/pushing
- Using brace when out of bed and proper application
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Stairs

Pt / family verbalized / demo good understanding of educational interventions

Interdisciplinary Communication: none needed

After therapy: Nursing aware of current status, Remained in chair and Family present
Call light within reach - tubes and lines intact

Signature: Jennifer Couto, PTA 56728/ Marisa Balagtas, PT 51273

Previous Versions
11/28/11 1509 PT/OT Progress Note Signed By Jennifer Couto

PT/OT Progress Note signed by Paul Leitz at 11/28/11 1545

Author: Paul Leitz Service: (none) Author Type: (none)
Filed: 11/28/11 1545 Note Time: 11/28/11 1515
Related Notes: Original Note by: Luke Windon filed at 11/28/11 1537

OCCUPATIONAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 4 Rx Start time: 2:45 Total Treatment Time 25 minutes 9491/92/9491

Current Activity Orders: Progressive activity

Discharge Recs: Subacute Rehab
DURABLE MEDICAL EQUIPMENT / ASSISTIVE DEVICE RECOMMENDATION:
bedside commode and shower bench

ASSESSMENT (Summary of Findings): Pt agreeable and seen bedside and agreeable to tx.

Variance to Clinical Pathway: None

PLAN:
ADL retraining, Mobility/transfer training as related to ADLs and Safety training

SUBJECTIVE: "I'm planning on going to a rehab for a short stay."

OBJECTIVE:
Explained role of Occupational Therapy in patient's care.

Pain:
At rest: 4 /10
Post treatment: 5 /10
Patient's pain goal: 0 /10
Location: Back pain Quality: constant and aching

Pain Management Techniques:
arranged premedication before treatment, repositioning and mobility/exercise

Observation:
Brace NA
None

ADL: Instructed patient in modified techniques:

Pt. performed task:	Current Status	Comments
Feeding	Not assessed	
Grooming	Not assessed	
Upper body dressing	Not assessed	
Lower body dressing	Not assessed	
Upper body bathing	Not assessed	
Lower body bathing	Not assessed	
Toileting	Not assessed	
Bed Mobility – side to side	Minimal assistance	manual cues, verbal cues, using rail and head of bed elevated
Bed Mobility – supine to/from sit	Minimal assistance	manual cues, verbal cues, using rail and head of bed flat
Bed to chair transfer	Minimal assistance	standing walking transfer, verbal cues and manual cues
Toilet/commode transfer	Standby assistance or setup	standing walking transfer and verbal cues
Tub/shower transfer	Minimal assistance	
Car transfers	Not assessed	
Functional mobility for ADL	Minimal assistance	
Safety with walker for ADL	fair	
Sit to stand with / without walker	Supervision or setup	instructed to push off of bed/armrests, standing walking transfer and verbal cues
Brace Management for ADL	Not assessed	

	STATIC	DYNAMIC	TOLERANCE

	BALANCE	BALANCE	
Sitting	fair	fair	fair tolerance
Standing	fair	fair	fair tolerance

Treatment Provided: Instruct given to pt on bed mobility, toilet tsf, shower tsf with pt demo. Educated pt on hip precautions with pt recalling 3/3. Pt required MIN VC's for walker safety during tsf's.

Transfers with Rolling Walker
Weight Bearing Status: Full weightbearing bilateral UE's and LE's

PATIENT EDUCATION:
Instructed patient in:
Brace Management NA
surgical specific precautions as related to ADLs, bed mobility with modified technique, safety with ADL transfers and modified self-care techniques

patient needs follow up teaching regarding educational interventions

Handouts Provided:
not applicable

Therapeutic Procedure: None

Interdisciplinary Communication: NA

After Therapy: Remained in chair
Call light within reach - tubes and lines intact

Key:
I = Independent, Mod I - Modified Independent with assistive device, safety or time considerations, MIN = Minimal Assist, MOD = Moderate Assistance, MAX = Maximal Assistance, DEP = Dependent

MMT=Manual Muscle Testing WFL=Within Functional Limits WNL=Within Normal Limits ROM = Range of Motion 1=Trace (slight contraction); 2=Poor (gravity eliminated); 3=Fair (against gravity); 4=Good (tolerates some resistance); 5=Normal

Signature: Luke Windon COTAL 54537; Paul M Leitz OTR/L 51388

Previous Versions
11/28/11 1537 PT/OT Progress Note Signed By Luke Windon

Care Management signed by Lisa R George at 11/28/11 1359

Author: Lisa R George Service: (none) Author Type: Social Worker
Filed: 11/28/11 1359 Note Time: 11/28/11 1357

Awaiting approval from Caretel of Brighton for SAR placement. Wife to drive. LGeorge LMSW 59169

Consults signed by Thomas D Kim, MD at 11/28/11 0824

Author: Thomas D Kim, MD Service: (none) Author Type: Physician
Filed: 11/28/11 0824 Note Time: 11/23/11 1217
Related Notes: Original Note by: Thomas D Kim, MD filed at 11/23/11 1437

INTERNAL MEDICINE CONSULTATION

ATTENDING PHYSICIAN: Dr. DAVID MONTGOMERY
CONSULTING PHYSICIAN: Dr. Thomas D Kim M.D.

PRIMARY CARE PHYSICIAN: Dr. K. Karadsheh

DATE OF CONSULTATION: 11/23/2011

REASON FOR CONSULTATION: Hypertension, diabetes management.

HISTORY OF PRESENT ILLNESS: The patient is a 60-year-old male who has known lumbar spinal stenosis and prior lumbar laminotomy surgery, who presented for elective lumbar decompression surgery. Patient had failed outpatient conservative management. There had been no recent complaints including fevers, chills, nausea, emesis, chest pain, or shortness of breath. Patient underwent L4, L5 and S1 decompression and lateral fusion surgery as well as bone graft on 11/22/2011. Patient is now postop day #1. Patient is complaining of back pain at this time. He has no other complaints currently. His blood pressures have been stable. His blood glucoses have also been stable. There are no current complaints of fevers, chills, nausea, emesis, chest pain, or shortness of breath.

REVIEW OF SYSTEMS: As above in history of present illness. All other systems were reviewed and are negative.

PAST MEDICAL HISTORY: Spinal stenosis, spondylolisthesis, postlaminectomy syndrome, anxiety, diabetes mellitus, hypertension, hyperlipidemia, and GERD.

PAST SURGICAL HISTORY: Recent L4, L5 and S1 decompression surgery with lateral fusion and bone graft, arthrodesis of the right hallux metatarsophalangeal joint, right rotator cuff repair, L4, L5 and S1 laminotomy, and L5 to S1 left discectomy, appendectomy, and uvula resection.

MEDICATIONS: Please see medication reconciliation in EPIC.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: Sister had ovarian cancer and mother had Parkinson's disease.

SOCIAL HISTORY: Patient is an ex-smoker. He rarely drinks alcohol. He is married. He lives with his son. Patient is a retired auto transporter via rail.

PHYSICAL EXAMINATION: Vitals: Blood pressure 123/61, heart rate 87, respiratory rate 18, temperature afebrile. Patient is on room air. General: Patient does appear to be in at least mild distress secondary to pain. He is otherwise nontoxic in appearance. He is alert and awake. HEENT: Pupils equal, round and reactive to light and accommodation. Extraocular eye movements are intact. Neck is supple. Mucous membranes are moist. Chest: Clear to auscultation bilaterally. Cardiac: Regular rate and rhythm. S1, S2. No murmurs. Abdomen: Bowel sounds in all quadrants. Soft, nontender, nondistended. Back: Postoperative site is clean, dry and intact. There is a drain in place. Extremities: No clubbing, no cyanosis, no edema. Patient has 2+ pulses throughout. Psychiatric: Affect is appropriate. Patient does not appear anxious at this time. Neurologic: Patient is alert and oriented times 3. Patient reports subjective lower extremity paresthesias which are chronic. This is worse in his right foot. Otherwise, no other focality is appreciated on examination.

LABS AND IMAGING: All reviewed in EPIC.

IMPRESSION AND RECOMMENDATIONS:
The patient is a 60-year-old male with back pain.

1. Musculoskeletal. Postlaminectomy syndrome and spinal stenosis status post L4, L5 and S1 decompression surgery with fusion and bone graft. Management is per the primary service.

2. Cardiac. (a) Hypertension. This is stable on his current blood pressure regimen. This may continue to be monitored.
(b) Hyperlipidemia. Patient is on a statin.

3. Endocrine. Diabetes mellitus type 2. Patient may continue with sliding scale insulin. His oral medications are to be held while inpatient. His blood glucose levels are at goal for inpatient management. This may continue to be monitored.

4. GI. The patient is on a proton pump inhibitor.

5. Psychiatric. Anxiety. Patient may continue his benzodiazepine regimen as needed.

6. DVT prophylaxis. Patient is on SCDs per Primary Service.

DISPOSITION: Will follow-up on the patient tomorrow. Thank you for the consultation.

Previous Versions
11/23/11 1437 Consultation By Thomas D Kim, MD

Nsg Progress Note signed by Kristin L McErlean at 11/27/11 2309

Author: Kristin L McErlean | Service: (none) | Author Type: Nursing
Filed: 11/27/11 2309 | Note Time: 11/27/11 2300
Related Notes: Original Note by: Kristin L McErlean filed at 11/27/11 2308

Pt is AOx3, VSS, neurovasculars intact. Voiding without difficulty. Pt reports nerve pain in RLE. Pt is able to ambulate with walker. Dressing to back is CDI. Paged Dr. Green (20605) to notify him that pt had reached acetaminophen maximum of 4,000mg in 24 hours. Dr. Green added 5mg of roxicodone to PRN medications for pain relief. Will administer medication per orders and continue to monitor. Call light within reach.

Previous Versions
11/27/11 2308 Nsg Progress Note Signed By Kristin L McErlean

Care Management signed by Bitool Gulla at 11/27/11 1430

Author: Bitool Gulla | Service: (none) | Author Type: Registered Nurse
Filed: 11/27/11 1430 | Note Time: 11/27/11 1429

11/27,pt lst choice caretel inns in brighton referral has been sent via ecin.bg 55336

Care Management signed by Bitool Gulla at 11/27/11 1338

Author: Bitool Gulla | Service: (none) | Author Type: Registered Nurse
Filed: 11/27/11 1338 | Note Time: 11/27/11 1337

11/27,cc checked with pt on facility choices, pt stated the family touring the facility and they will get back with choices.cc need to follow.bg 55336

PT/OT Progress Note signed by Danita C. Weber at 11/27/11 1247

Author: Danita C. Weber | Service: (none) | Author Type: Physical Therapist
Filed: 11/27/11 1247 | Note Time: 11/27/11 1213
Related Notes: Original Note by: Katharina Denning filed at 11/27/11 1220

PHYSICAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 4 Rx Start time: 10:20 Total Treatment Time 25 min. Room Number: 9491/92/9491

Discharge Recs: Subacute Rehab
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity

ASSESSMENT (Summary of Findings): Patient tolerated therapy session well. Patient presents with

difficulty performing functional activities/mobility due to weakness, decreased endurance and pain. Patient is progressing well. Patient with slow gait, with use of rolling walker. Noted lower extremity weakness. Gait belt on for safety.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Logrolling bed mobility	Supervision or setup , Minimal assistance	logroll/sidelying, manual cues, verbal cues and head of bed flat
Transfers: sidely ↔ sit	Supervision or setup , Minimal assistance	logroll/sidelying, manual cues, verbal cues and head of bed flat
Transfers: sit ↔ stand	Minimal assistance	instructed to push off of bed/armrests, verbal cues, manual cues and with assistive device
Gait:	Minimal assistance	60 feet with Rolling Walker, Full weightbearing bilateral UE's and LE's, Decreased step length, Antalgic, Slow and Step through
Brace management	Not appropriate	
Stairs:	Not assessed	Not safe to practice stairs at this time

PLAN:
Continue PT until goals achieved. Next treatment session will address:
- Bed Mobility
- Transfers
- Gait Training
- Stairs
- Education regarding precautions

SUBJECTIVE: Patient seen bedside, lying in bed ready for therapy.
Patient agrees to physical therapy treatment

OBJECTIVE:
Pt/family educated on role of Physical Therapy

Pain:
At Rest: 8 /10
With Activity: 8 /10
Patient's pain goal: 0 /10
Location: back Quality: aching

Pain management techniques:
RN Notified
Repositioning
Mobility/Exercise
Deep Breathing

Observation:
In bed before treatment

BALANCE STATUS	STATIC	DYNAMIC
Sitting	Good	Fair
Standing	Fair, With assistive device	Fair, With assistive device

Endurance: Tolerated well

PATIENT EDUCATION:
Instructed patient / family on:

- Spinal precautions including no bending, lifting, twisting; no pulling/pushing
- Using brace when out of bed and proper application
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Stairs

Pt / family verbalized / demo good understanding of educational interventions

Interdisciplinary Communication: Spoke with RN regarding mobility status and tolerance to treatment

After therapy: Remained in bed and HOB up 30 degrees
Call light within reach - tubes and lines intact

Signature: Katharina Denning,PTA56928
Danita C. Weber, DPT, #55493

Previous Versions
11/27/11 1220 PT/OT Progress Note Signed By Katharina Denning

Nsg Progress Note signed by Carrie L Loder at 11/27/11 0058

Author: Carrie L Loder Service: (none) Author Type: Nursing
Filed: 11/27/11 0058 Note Time: 11/27/11 0056

NURSING PLAN OF CARE NOTE
See Active Problem List:

PROBLEM(S):

Pain r/t: DLL INTERVENTIONS: Dilaudid, Lortab PRN, repositioning PRN EVALUATION: Stable states better pain relief this shift
Alt. Mobility: r/t: DLL INTERVENTIONS: up with walker EVALUATION: Stable good stability when up, getting up slowly
Skin Integrity: r/t: DLL INTERVENTIONS: Incision assessment QS, bandage in place EVALUATION: Stable incision CDI

Carrie Loder , 11/27/2011 12:56 AM

PT/OT Progress Note signed by Christine M Koch at 11/26/11 1212

Author: Christine M Koch Service: (none) Author Type: Occupational Therapist
Filed: 11/26/11 1212 Note Time: 11/26/11 1205

OCCUPATIONAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 3 Rx Start time: 11:40 Total Treatment Time 25 minutes 9491/92/9491

Current Activity Orders: Up ad lib

Discharge Recs:Subacute Rehab
DURABLE MEDICAL EQUIPMENT / ASSISTIVE DEVICE RECOMMENDATION:

to be determined, by SAR

ASSESSMENT (Summary of Findings): Pt tol tx fair. Pt up in bathroom. Pt performed rolling commode t/f req SBA. Pt performed toileting SBA. Pt performed functional mobility community dist with RW req min A..Pt c/o 20/10 pain down R LE. Pt sat up bedside chair 10 min and returned supine via log roll req min A.

Pt would benefit from continued skilled instruct to increase safety and I for functional needs.

Variance to Clinical Pathway: None

PLAN:
Diagnosis and patient specific education, ADL retraining, Mobility/transfer training as related to ADLs, Safety training and Energy conservation

SUBJECTIVE: "It is my right leg"

OBJECTIVE:
Explained role of Occupational Therapy in patient's care.

Pain:
At rest: 20 /10
Post treatment: 20 /10
Patient's pain goal: 0 /10
Location: R leg Quality: burning, radiating and sharp

Pain Management Techniques:
Nursing notified and repositioning

Observation:
Brace NO
In bathroom

ADL: Instructed patient in modified techniques:

Pt. performed task:	Current Status	Comments
Feeding	Activity not completed	
Grooming	Activity not completed	
Upper body dressing	Activity not completed	
Lower body dressing	Activity not completed	
Upper body bathing	Activity not completed	
Lower body bathing	Activity not completed	
Toileting	Supervision or setup	
Bed Mobility – side to side	Minimal assistance	logroll/sidelying, manual cues, verbal cues and head of bed flat
Bed Mobility – supine to/from sit	Minimal assistance	logroll/sidelying, manual cues, verbal cues and head of bed flat
Bed to chair transfer	Supervision or setup	instructed to push off of bed/armrests, standing walking transfer and verbal

		cues
Toilet/commode transfer	Supervision or setup	instructed to push off of bed/armrests, standing walking transfer, verbal cues and with assistive device
Tub/shower transfer	Activity not completed	
Car transfers	Activity not completed	
Functional mobility for ADL	Minimal assistance	
Safety with walker for ADL	fair	
Sit to stand with / without walker	Minimal assistance	instructed to push off of bed/armrests, standing walking transfer, verbal cues and manual cues
Brace Management for ADL	Not appropriate	

	STATIC BALANCE	DYNAMIC BALANCE	TOLERANCE
Sitting	fair	fair	10 minutes
Standing	fair	fair	5 minutes

Treatment Provided: bed mobility via log roll tech, safety with hand placement with functional t/f's, safety with walker during functional mobility, spine precautions, D/C plan

Transfers with Rolling Walker
Weight Bearing Status: Full weightbearing bilateral UE's and LE's

PATIENT EDUCATION:
Instructed patient in:
Brace Management NO
surgical specific precautions as related to ADLs, home safety, energy conservation, bed mobility with modified technique and safety with ADL transfers

patient needs follow up teaching regarding educational interventions

Handouts Provided:
not applicable

Therapeutic Procedure: None

Interdisciplinary Communication: RN re: pt request for pain meds

After Therapy: Nursing aware of current status and Remained in bed
Call light within reach - tubes and lines intact

Key:
I = Independent, Mod I - Modified Independent with assistive device, safety or time considerations, MIN = Minimal Assist, MOD = Moderate Assistance, MAX = Maximal Assistance, DEP = Dependent

MMT=Manual Muscle Testing WFL=Within Functional Limits WNL=Within Normal Limits ROM = Range of Motion 1=Trace (slight contraction); 2=Poor (gravity eliminated); 3=Fair (against gravity); 4=Good (tolerates some resistance); 5=Normal

Signature: C. Koch OTR/L 55382

Nsg Progress Note signed by Cheryl Shelson, RN at 11/26/11 1128

Author: Cheryl Shelson, RN Service: (none) Author Type: Registered Nurse
Filed: 11/26/11 1128 Note Time: 11/26/11 1125

Pt A&O x3. Back dressing CDI. Toes and fingers warm and mobile with positive pulses and good cap refill. Pt up ambulating with walker. Pain rated at 10 this AM 10 on pain scale. lortab and dilaudid given and pt states some relief. 5 on pain scale. Mobility encouraged. Tolerating diet. Blood sugars covered per SS prn. VSS. Blood pressure meds held this AM for BP 105/57. Pt voiding without difficulty. Last BM 11/25. Discharge home cancelled as pt is going to ECF on discharge. Will monitor.

PT/OT Progress Note signed by Kathleen Graca at 11/26/11 1043

Author: Kathleen Graca Service: (none) Author Type: Physical Therapist
Filed: 11/26/11 1043 Note Time: 11/26/11 1043

Spoke with patient who states he is going home today, he also states there is nothing he wishes to review prior to being discharged, declined PT on this date

Nsg Progress Note signed by Donna Petrylak, RN at 11/26/11 0134

Author: Donna Petrylak, RN Service: (none) Author Type: Registered Nurse
Filed: 11/26/11 0134 Note Time: 11/26/11 0133

P:Pain r/t surgery
I:pt. Medicated x1 per order for c/o discomfort
E:pt. Verbalized relief with pain med.,resting ,dressing to back D/i,skin warm and dry,stable.

Nsg Progress Note signed by Kristin L McErlean at 11/25/11 2125

Author: Kristin L McErlean Service: (none) Author Type: Nursing
Filed: 11/25/11 2125 Note Time: 11/25/11 2123

Pt is AOx3, VSS, neurovasculars intact. Voiding without difficulty. BM this evening. Pt reports nerve pain in RLE. Pt is able to ambulate with walker. Dressing to back is CDI: Medicated for pain per orders. Call light within reach. Will continue to monitor.

Spiritual Care signed by Arul J Sundaradhas at 11/25/11 1812

Author: Arul J Sundaradhas Service: (none) Author Type: (none)
Filed: 11/25/11 1812 Note Time: 11/25/11 1812

The patient asked for prayers and I prayed

PT/OT Progress Note signed by Christine M Koch at 11/25/11 1636

Author: Christine M Koch Service: (none) Author Type: Occupational Therapist
Filed: 11/25/11 1636 Note Time: 11/25/11 1539
Related Notes: Original Note by: Luke Windon filed at 11/25/11 1554

OCCUPATIONAL THERAPY PROGRESS NOTE
SPINAL SURGERY CLINICAL PATHWAY

Visit: 2 Rx Start time: 2:40 Total Treatment Time 25 minutes 9491/92/9491

Current Activity Orders: Progressive activity

Discharge Recs:Home with 24 hour assistance, Inpatient Rehab Unit
DURABLE MEDICAL EQUIPMENT / ASSISTIVE DEVICE RECOMMENDATION:
bedside commode and tub transfer bench

ASSESSMENT (Summary of Findings): Pt agreeable and seen in dept with increased pain

Variance to Clinical Pathway: None

PLAN:
ADL retraining, Mobility/transfer training as related to ADLs and Safety training

SUBJECTIVE: "I'm in so much pain, I can't sit very long."

OBJECTIVE:
Explained role of Occupational Therapy in patient's care.

Pain:
At rest: 20 /10
Post treatment: 20 /10
Patient's pain goal: 0 /10
Location: Back pain Quality: constant, aching and radiating

Pain Management Techniques:
Nursing notified, arranged premedication before treatment, repositioning and mobility/exercise

Observation:
BraceNA
None

ADL: Instructed patient in modified techniques:

Pt. performed task:	Current Status	Comments
Feeding	Not assessed	
Grooming	Not assessed	
Upper body dressing	Not assessed	
Lower body dressing	Not assessed	
Upper body bathing	Not assessed	
Lower body bathing	Not assessed	
Toileting	Not assessed	
Bed Mobility – side to side	Not assessed	not assessed
Bed Mobility – supine to/from sit	Not assessed	not assessed
Bed to chair transfer	Not assessed	not assessed
Toilet/commode transfer	Not assessed	not assessed
Tub/shower transfer	Not assessed	
Car transfers	Minimal assistance	
Functional mobility for ADL	Supervision or setup	
Safety with walker for ADL	fair	
Sit to stand with / without walker	Minimal assistance	standing walking transfer and verbal cues
Brace Management for ADL	Not assessed	

	STATIC BALANCE	DYNAMIC BALANCE	TOLERANCE
Sitting	fair	fair	fair tolerance
Standing	fair	fair	fair tolerance

Treatment Provided: Instruct given to pt on Suv tsf with pt demo. Pt in extreme pain and declined toilet and shower tsf's. Educated pt on spine precautions with pt recalling.

Transfers with Rolling Walker
Weight Bearing Status: Full weightbearing bilateral UE's and LE's

PATIENT EDUCATION:

Instructed patient in:
Brace Management NA
surgical specific precautions as related to ADLs, car transfers, safety with ADL transfers and modified self-care techniques

patient needs follow up teaching regarding educational interventions

Handouts Provided:
not applicable

Therapeutic Procedure: None

Interdisciplinary Communication: NA

After Therapy: Remained in chair
Call light within reach - tubes and lines intact

Key:
I = Independent, Mod I - Modified Independent with assistive device, safety or time considerations, MIN = Minimal Assist, MOD = Moderate Assistance, MAX = Maximal Assistance, DEP = Dependent

MMT=Manual Muscle Testing WFL=Within Functional Limits WNL=Within Normal Limits ROM = Range of Motion 1=Trace (slight contraction); 2=Poor (gravity eliminated); 3=Fair (against gravity); 4=Good (tolerates some resistance); 5=Normal

Signature: Luke Windon COTAL 54537
C. Koch OTR/L 55382

Previous Versions
11/25/11 1554 PT/OT Progress Note Signed By Luke Windon

Care Management signed by Tera Dmytryszyn at 11/25/11 1623

Author:	Tera Dmytryszyn	Service:	(none)	Author Type:	Registered Nurse
Filed:	11/25/11 1623	Note Time:	11/25/11 1621		

11/25 PT rec: home w/assist vs SAR. Pt states wife has MS & cannot assist him. List given to pt for Livingston County SAR per request.CC encouraged to pt have family/friends tour facilities and give CC choices.Pt verbalized understanding. Pt states: Workmans comp CM is: Bridgette Green (313) 299-2115. CC left message w/callback #. RN is going to call resident and inform of the above and ask for CXR for ecf placement. Pt aware may not be able to get bed until Monday. Td. 52287.

PT/OT Progress Note signed by Joanna Hadsell at 11/25/11 1548

Author:	Joanna Hadsell	Service:	(none)	Author Type:	Physical Therapist
Filed:	11/25/11 1548	Note Time:	11/25/11 1431		
Related Notes:	Original Note by: Michelle Winalis filed at 11/25/11 1435				

PHYSICAL THERAPY PROGRESS NOTE
SPINAL SURGERY-CLINICAL PATHWAY

Visit: 3 Rx Start time: 14 15 Total Treatment Time 25 min. Room Number: 9491/92/9491

Discharge Recs: Home with assistance PRN, Subacute Rehab
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity

ASSESSMENT (Summary of Findings): Patient tolerated therapy session good. Patient presents with difficulty performing functional activities/mobility due to decreased balance, weakness, decreased endurance and pain. Patient is progressing good. Patient was seen in department gym. Patient was able to perform curb step with min assist and RW.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Logrolling bed mobility	Not assessed	
Transfers: sidely ↔ sit	Not assessed	
Transfers: sit ↔ stand	Supervision or setup	instructed to push off of bed/armrests and verbal cues
Gait:	Supervision or setup	60 feet with Rolling Walker, Full weightbearing bilateral UE's and LE's, Normal cadence and step length and Slow
Brace management	Not appropriate	
Stairs:	Minimal assistance and Instruction provided, good understanding verbalized	4" curb step

PLAN:
Continue PT until goals achieved. Next treatment session will address:
- Bed Mobility
- Transfers
- Gait Training
- Stairs
- Education regarding precautions

SUBJECTIVE: Patient states I am in a lot of pain
Patient agrees to physical therapy treatment

OBJECTIVE:
Pt/family educated on role of Physical Therapy

Pain:
At Rest: 10 /10
With Activity: 10 /10
Patient's pain goal: 0 /10
Location: LB Quality: aching

Pain management techniques:
RN Notified
Repositioning
Mobility/Exercise
Deep Breathing

Observation:
Up in chair before treatment

BALANCE STATUS	STATIC	DYNAMIC
Sitting	Good	Good
Standing	Fair+, Fair, With assistive	Fair, With assistive device,

	device, With UE support	With UE support

ADDITIONAL TREATMENT PROVIDED: TE, gait training, curb step, spine precautions ed
Endurance: Tolerated well

PATIENT EDUCATION:
Instructed patient / family on:

- Spinal precautions including no bending, lifting, twisting; no pulling/pushing
- Using brace when out of bed and proper application
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Stairs

Pt / family verbalized / demo good understanding of educational interventions

Interdisciplinary Communication: none
After therapy: Remained in chair
Call light within reach - tubes and lines intact

Signature: Michelle Winalis PTA 56845/ Joanna Hadsell, MPT

Previous Versions
11/25/11 1435 PT/OT Progress Note Signed By Michelle Winalis

Nsg Progress Note signed by Denise Jones, RN at 11/25/11 1313

Author: Denise Jones, RN Service: (none) Author Type: Registered Nurse
Filed: 11/25/11 1313 Note Time: 11/25/11 1307

P:pain r/t posterior dll. I:pt. Will have pain control. E: Pt. Presently with C/o back and mainly leg pain that is nerve pain. Has been using Dilaudid and Lortab as ordered. Neurontin also started.. .P:mobility r/t posterior dll. Pt, monitored while Ambulated with steady gait. To bathroom.E: Pt. Ambulates with steady gait. P:skin integrity r/t posterior dll.I:pt. Will have no breakdown or s/s of infection. E: Lower back dressing cdi. Iv also cdi. .P:elimination r/t pain meds and posterior dlll:patterns will be monotored, meds given as ordered..Pt. Voids freely qs clear, yellow urine. No bm. P:neurovascular r/t posterior dlll: To maintain appropriate status.E: All toes warm, mobile, with brisk refill upon blanches bilaterlpedal.pulses strong. .P: Education r/t left tka. I: pt. Will verbalize understanding of all information. E: pt. Verbalizes understanding of medications, , and floor routines, P.T., O.T., P:neurovascular r/t posterior dll. I:s/s of impairment will be monitored and reported. E:pt. Without c/o numbness,tingling, or weakness.

Nsg Progress Note signed by Jenna L Dural, RN at 11/24/11 1904

Author: Jenna L Dural, RN Service: (none) Author Type: Registered Nurse
Filed: 11/24/11 1904 Note Time: 11/24/11 1902

NURSING PLAN OF CARE NOTE
See Active Problem List:

PROBLEM(S):

Pain r/t: back surgery
INTERVENTIONS: assess pain every shift and after pain medication has been given
EVALUATION: Pain controlled on ordered medications (see emar)

Alt. Mobility: r/t: ortho surgery
INTERVENTIONS: encourage ambulation to increase mobility
EVALUATION: Pt has improved mobility since this morning upon early assessment worked with therapy as

ordered (see therapy notes) up walking around in halls

Safety: r/t Pain medications
INTERVENTIONS: call light in reach, pt educated on how to call RN/NA, hourly rounding
EVALUATION: pt maintained safety throughout shift, no issues

Risk for Falls: r/t Pain medication, ortho surgery
INTERVENTIONS: call light and phone in reach, pt educated on how to call RN/NA, hourly rounding
EVALUATION: No issues with falls, pt called When needed for ambulation, hourly rounding done

Neurovascular: r/t Back surgery
INTERVENTIONS: assess NV status per orders
EVALUATION: NV status intact at this time see one chart for other assessments (pt has hx of numbness/tingling to lower extremities)

PT/OT Progress Note signed by Danita C. Weber at 11/24/11 1428

Author: Danita C. Weber Service: (none) Author Type: Physical Therapist
Filed: 11/24/11 1428 Note Time: 11/24/11 1120
Related Notes: Original Note by: Julie Perry filed at 11/24/11 1129

PHYSICAL THERAPY PROGRESS NOTE
GENERAL ORTHOPEDIC

Visit: 2 Rx Start time: 9:00am Total Treatment Time 30 min. Room Number: 9491/92/9491

Discharge Recs: Home with assistance PRN, Subacute Rehab
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity

ASSESSMENT (Summary of Findings): Patient tolerated therapy session good. Patient presents with difficulty performing functional activities/mobility due to weakness and pain. Patient is progressing good.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Bed Mobility	Minimal assistance	logroll/sidelying
Transfers: sit ↔ stand	Minimal assistance, Moderate assistance	standing walking transfer
Transfers: bed ↔ chair	Minimal assistance, Moderate assistance	standing walking transfer and verbal cues
Gait:	Minimal assistance	120 feet times 2with Rolling Walker, Full weightbearing bilateral UE's and LE's, Antalgic, Wide base of support and Slow
Stairs:	Not assessed	0 stairs today

PLAN:
Continue PT until goals achieved. Next treatment session will address:
- Bed Mobility
- Transfers
- Gait Training
- HEP/Exercises
- Stairs

SUBJECTIVE: Patient states he was sorry for being grumpy this morning but he was in a lot of pain but feels better now
Patient agrees to physical therapy treatment

OBJECTIVE:
Pt/family educated on role of Physical Therapy

Pain:
At Rest: 9 /10
With Activity: 6 /10
Patient's pain goal: 1 /10
Location: Back and legs Quality: constant, sharp and stabbing

Pain management techniques:
Nurse adminstered medication before PT came back

Observation:
Telemetry monitor and Continuous pulse oximetry

BALANCE STATUS	STATIC	DYNAMIC
Sitting	Good	Good
Standing	Good, Fair+	Good, Fair+

PATIENT EDUCATION:
Instructed patient / family on:
- Appropriate weight bearing status
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Home Exercise Program

Pt / family needs follow up teaching regarding educational interventions

Therapeutic Exercises:
Instructed patient to complete the below exercises 3 x per day, as tolerated.

All exercises performed AROM 2 set X 10 reps. Isometric exercises held for 5-10 seconds, unless otherwise noted

Ankle pumps, Gluteal sets and Long arc quads

Interdisciplinary Communication: Spoke with RN regarding tolerance to treatment

After Therapy: Nursing aware of current status and Remained in chair
Call light within reach - tubes and lines intact

Signature: Julie Perry PTA 52533
Danita C. Weber, DPT, #55493

Previous Versions
11/24/11 1129 PT/OT Progress Note Signed By Julie Perry

PT/OT Progress Note signed by Rebecca Tofteland at 11/24/11 0936

Author: Rebecca Tofteland Service: (none) Author Type: Occupational Therapist
Filed: 11/24/11 0936 Note Time: 11/24/11 0928

ORTHOPEDIC OCCUPATIONAL THERAPY EVALUATION AND TREATMENT

Initial

Visit: 1 Rx Start time: 9:00-9:30 Total Treatment Time 30 min. Room Number: 9491/92/9491

See PT/OT database form.

Current Activity Orders: Progressive activity

Discharge Recs: Home with 24 hour assistance, Inpatient Rehab Unit
DURABLE MEDICAL EQUIPMENT / ASSISTIVE DEVICE RECOMMENDATION:
bedside commode, tub transfer bench, reacher and sock aide

ASSESSMENT (Summary of Findings): pt limited in ability to complete mobility secondary to RLE pain. He reports that his wife is unable to provide assistance with transfers/mobility and he will need to be mod I with these in order to return home safely. He exhibits decreased balance, strength and difficulty with sit-stand portions of transfers.

Variance to Clinical Pathway: None

PLAN OF CARE:
Next treatment session will address:
Diagnosis and patient specific education, ADL retraining, Mobility/transfer training as related to ADLs, Safety training, Eval for DME and Energy conservation

FREQUENCY:
2-3 times per week

GOALS: In preparation for D/C to the next level of care. In 3 visits patient will demonstrate:

Verbalize good understanding for safe ADL techniques with equipment as needed
Verbalize good understanding of bed mobility techniques with or without use of leg lifter as appropriate
Verbalize good understanding for safe ADL transfers with modified techniques, as needed.
Improve ADL with safety: Supervision or setup , Minimal assistance
Improve bed mobility/positioning to: Minimal assistance
Improve safe ADL transfers to: Supervision or setup

Pt demonstrates/verbalizes good understanding of safety/precautions for ADL and functional mobility
Pt verbalizes good understanding of energy conservation techniques for ADL
Improve both arms UE 1/3 grade
Independent with UE HEP
Pt will report less than 4/10 pain with ADL and functional mobility

SUBJECTIVE: Pt agreeable to OT
Patient attended pre-operative class.

Patient/Family Goals:
Same as functional goals
Goals and treatment plan discussed with patient / family
Patient / family verbalized understanding and are in agreement.

OBJECTIVE:
Explained role of Occupational Therapy in patient's care.

Pain:
At rest: 8 /10
Post treatment: 8 /10
Patient's pain goal: 0 /10
Location: RLE Quality: intermittent and radiating

Pain Management Techniques:
repositioning and pt reports this is ongoing pain and that he already received pain meds

Observation:
None

EVALUATION:

EXAMINATION	CURRENT STATUS
Mentation	Intact and A + O x3
Upper Body Range of Motion	ROM WFL Bilateral UE's/LE's
Upper Body Strength	Minimally decreased strength Bilateral UE's
Upper Extremity Coordination	intact
Upper Extremity Sensation	intact

PATIENT INTERVENTION:
ADL: Instructed patient in safe modified techniques for:

	CURRENT STATUS	COMMENTS
Feeding	Independent	
Grooming	Supervision or setup	
Upper body dressing	Supervision or setup	
Lower body dressing	Maximal assistance	
Upper body bathing	Supervision or setup	
Lower body bathing	Maximal assistance	
Toileting	Maximal assistance	
Brace management		

FUNCTIONAL MOBILITY: Instructed patient in safe modified techniques for:

		CURRENT STATUS	COMMENTS
Side to Side		Moderate assistance	logroll/sidelying
Supine ↔ Sit		Moderate assistance	logroll/sidelying
Sitting Balance for ADL:	Static	good	
	Dynamic	fair	
	Tolerance for Sitting	approximately 30 minutes	
Standing Balance for ADL	Static	fair	
	Dynamic	fair	
	Tolerance for Standing	3 minutes	
Transfers with	Bed to Chair	Minimal assistance, Moderate assistance	standing pivot and standing walking transfer
Rolling Walker	Toilet	Moderate	standing pivot and standing walking

		assistance	transfer
	Tub/Shower	Moderate assistance	
	Sit to/from Stand	Minimal assistance, Moderate assistance	standing pivot and standing walking transfer
	Car Transfers	Not assessed	

Treatment Provided: instruct in ADLs within spine precautions, transfers, energy conservation and dme

Weight Bearing Status: Full weightbearing bilateral UE's and LE's

PATIENT EDUCATION:
Instructed patient / family on:
surgical specific precautions as related to ADLs, home safety, energy conservation, bed mobility with modified technique, safety with ADL transfers and modified self-care techniques

patient needs follow up teaching regarding educational interventions

Therapeutic Exercises: None

PATIENT PRESENTS WITH THE FOLLOWING DEFICITS:
- Requires assistance with ADL
- Requires assistance with bed mobility/positioning
- Requires assistance with ADL transfers
- Decreased balance affecting ADL
- Pt demos decreased awareness of safety regarding ADL and functional mobility
- Pt demos decreased both arms - upper extremity function /strength affecting ADL
- Pt demos decreased awareness of proper use of DME/assistive equipment/bracing
- Pt demos decreased awareness of orthopedic precautions
- Pain with ADL and functional mobility

Pt with Physical Therapy after Occupational Therapy session.
After Therapy: Remained in chair
Call light within reach - tubes and lines intact

Key:
I = Independent, Mod I - Modified Independent with assistive device, safety or time considerations, MIN = Minimal Assist, MOD = Moderate Assistance, MAX = Maximal Assistance, DEP = Dependent

MMT=Manual Muscle Testing WFL=Within Functional Limits WNL=Within Normal Limits ROM = Range of Motion 1=Trace (slight contraction); 2=Poor (gravity eliminated); 3=Fair (against gravity); 4=Good (tolerates some resistance); 5=Normal

Signature: Rebecca Tofteland, OTRL 57767

Nsg Progress Note signed by Michael Deligero Del Oeste, RN at 11/24/11 0557

Author: Michael Deligero Del Oeste, RN Service: (none) Author Type: Registered Nurse
Filed: 11/24/11 0557 Note Time: 11/24/11 0553

NURSING PLAN OF CARE NOTE
See Active Problem List:

PROBLEM(S):

Pain r/t: post lumbar laminINTERVENTIONS:given pain me[illegible]reposition on bed for comfort EVALUATION: Stable pt was able to sleep in long intervals

NURSING PLAN OF CARE NOTE
See Active Problem List:

PROBLEM(S):

Elimination: r/t post lumbar lami INTERVENTIONS:given po stool softener per bowel protocol
EVALUATION: Stable last bm 11/22/11

Michael Del Oeste , 11/24/2011 5:54 AM

Michael Del Oeste , 11/24/2011 5:53 AM

Nsg Progress Note signed by Kristin L McErlean at 11/23/11 2211

Author: Kristin L McErlean Service: (none) Author Type: Nursing
Filed: 11/23/11 2211 Note Time: 11/23/11 2210

Pt complaining of abdominal pain and cramping, last BM 11/22. Bowel sounds present x4. Miralax and dulcolax suppository administered. Medicated for pain per orders. Dressing to lower back is CDI. Hemovac has compression suction maintained. Awaiting results of bowel interventions. Will continue to monitor.

PT/OT Progress Note signed by Ravikumar Souriraian at 11/23/11 1621

Author: Ravikumar Souriraian Service: (none) Author Type: Physical Therapist
Filed: 11/23/11 1621 Note Time: 11/23/11 1602

PHYSICAL THERAPY EVALUATION AND TREATMENT
SPINAL SURGERY CLINICAL PATHWAY

Visit: 1 Rx Start time: 3:10 PM Total Treatment Time 40 min. Room Number: 9491/92/9491
See PT/OT Database Form

Discharge Recs: Home with assistance PRN, Home with 24 hour assistance
Durable medical equipment / Assistive device recommendation: Rolling Walker

Activity Level: Progressive activity with limitation of spine care precautions

ASSESSMENT (Summary of Findings): Patient tolerated therapy session fair. Patient presents with difficulty performing functional activities/mobility due to decreased balance, weakness and pain.

Variance to Clinical Pathway: None

FUNCTIONAL MOBILITY	CURRENT STATUS	TREATMENT PROVIDED / QUALITY / COMMENTS
Logrolling bed mobility	Minimal assistance	logroll/sidelying, manual cues, verbal cues and using rail
Transfers: sidely ↔ sit	Minimal assistance, Moderate assistance	logroll/sidelying, manual cues, verbal cues and using rail
Transfers: sit ↔ stand	Supervision or setup , Minimal assistance	instructed to push off of bed/armrests, verbal cues and manual cues
Gait:	Supervision or setup , Minimal assistance	120 feet with Rolling Walker, Full weightbearing bilateral UE's and LE's, Antalgic and Slow

Brace management	Not appropriate	
Stairs:	Not assessed	Not applicable

BALANCE EVALUATION	STATIC	DYNAMIC
Sitting	Good, With UE support	Fair+, Fair, With UE support
Standing	Good, Fair+, With assistive device	not assessed

PLAN OF CARE:
Physical Therapy is recommended to address deficits.
Bed mobility, Transfers, Gait training, Stairs and Pain management techniques and education

FREQUENCY:
1x/day for 5-7 days per week

GOALS: In preparation for D/C to next level of care. In 1-3 visits patient will demonstrate:

Bed mobility: Supervision or setup
Sit to stand: Supervision or setup
Stand to sit: Supervision or setup
Ambulate with: Rolling Walker for: 175 Level of assist: Supervision or setup , Minimal assistance
Up/down stairs as required by discharge situation: Supervision or setup
Improve sitting balance to Good
Improve standing balance to Good, With assistive device
Understands/demonstrates safe movement patterns and spinal precautions
Patient will be Independent with Pain Management Techniques

SUBJECTIVE: "I am having pain".
Patient agrees to physical therapy treatment.

Patient / Family Goals:
Same as functional goals.
Goals and treatment plan discussed with patient/family.
Patient/family verbalizes understanding and are in agreement

OBJECTIVE:
Explained role of Physical Therapy in patient's care

Pain:
At Rest: 6 /10
With Activity: 8 /10
Patient's pain goal: 0 /10
Location: back Quality: aching

Pain management techniques:
RN Notified
Repositioning
Mobility/Exercise
Deep Breathing

Observation:
Hemovac and Telemetry monitor

TESTS AND MEASURES:

EXAMINATION	CURRENT STATUS
Mentation	Intact and A + O x3
Range of Motion	Has ROM necessary to perform functional tasks related to general mobility
Strength	Grossly WFL x 4 (not MMT due to surgical pathway)

ADDITIONAL TREATMENT PROVIDED: Patient education
Endurance: Tolerated fair

PATIENT EDUCATION:
Instructed patient / family on:
- Spinal precautions including no bending, lifting, twisting; no pulling/pushing
- Safety and technique with transfers
- Ambulation
- Pain management techniques
- Stairs

Pt / family with good understanding regarding educational interventions

Handouts Provided:
Spine surgery booklet and Home Exercise Program

Interdisciplinary Communication: Spoke with RN regarding pain management

PATIENT PRESENTS WITH THE FOLLOWING DEFICITS:
- Pain S/P surgery
- Requires assistance with bed mobility
- Requires assistance with transfers
- Unable to ambulate safely without assistance on levels/steps
- Demonstrate decreased balance in sit / stand
- Unable to follow/unaware of spinal precautions

After Therapy: Nursing aware of current status and Remained in chair
Call light within reach - tubes and lines intact

Signature: Ravikumar Sourirajan PT, 56829.

Care Management signed by Judy Marie Galetto at 11/23/11 1331

Author: Judy Marie Galetto Service: (none) Author Type: Registered Nurse
Filed: 11/23/11 1331 Note Time: 11/23/11 1328

11/23/11: POD #1 Posterior Lumbar w/lami-fusion. Pt lives w/spouse, 1 STH, 2 STE. DME: RTS, glucometer. Pt states that he has a RW at home also but wanted to double check with his wife. No hx of HC/ECF. +Rx cov. Plan is home upon dc. No needs identified. JG 50506

Nsg Progress Note signed by Carrie Parker, RN at 11/23/11 1310

Author: Carrie Parker, RN Service: (none) Author Type: Registered Nurse
Filed: 11/23/11 1310 Note Time: 11/23/11 1304

Alert, Ox3 , s/p posterior bilat. laminectomy ,L4-S1 with fusion on 11/21 ,dressing c,d,i with hemovac compressed for bloody drainage. Neurovascular status intact,2+ pedal pulses, denies numbness or tingling, denies calf pains, thl/scd on bilat. le. Up with assist, lol. Well. Lungs clear, no sob.. Abd. soft, bs+. Tol. Diet well, refused noon insulin, bloodglucose=97. Voiding clear amber urine without problems,+ flatus,. No bm.The current medical regimen is effective; continue present plan and medications.C/O level 5-7/10, achey pains to back, stated relief with IV dilaudid and po lortabs. See E-mar.Afibrile, vital signs stable.TMS # 235, ONLY CALLED FOR O2 PROBE off, no chest pains, h/o sleep apnea. Continue to monitor.See shift assessment.

Nsg Progress Note signed by Noela James, RN at 11/23/11 0253

Author: Noela James, RN Service: (none) Author Type: Registered Nurse
Filed: 11/23/11 0253 Note Time: 11/23/11 0244

P: Pain r/t P BIL LAMI WITH FUSION

I : Encouraged patient to ask for pain meds when pain 4 or above.

E: Patient stated 6/10 REPOSITIONED AND MEDICATED WITH SHORT RELIEF

P: Mobility r/t POST BIL LAMI WITH FUSION

I: Encouraged pt to change position, ask for help with mobility

E: Pt ASSISTED WITH REPOSITIONING FOR COMFORT.

P: Skin integrity r/t POST BIL LAMI WITH FUSION

I : Instructed pt to change position frequently, elevate heels off bed, assess skin q shift.

E: Skin intact, dsg CDI. HEMOVAC IN PLACE WITH BLOODY DRAINAGE.

P: Elimination r/t POST BIL LAMI WITH FUSION

I : Encouraged fluids po, assist with toilleting.

E: Pt HAS FOLEY TO DD

P: Neurovascular r/t to POST BIL LAMI WITH FUSION.

I : Teds/ PCD ,NV q shift.

E: BIL UE AND LE warm, mobile, pulse normal.

P: Safety r/t POST BIL LAMI WITH FUSION.

I : Instructed pt to call for assistance with ambulation, call light within pt's reach.

E: Pt safe, no fall this shift.

Nsg Progress Note signed by Carrie Parker, RN at 11/22/11 1711

Author: Carrie Parker, RN Service: (none) Author Type: Registered Nurse
Filed: 11/22/11 1711 Note Time: 11/22/11 1706

RECEIVED INTO 9491 VIA BED FROM PACU THIS PM. ALERT, OX3, S/P POSTERIOR LUMBAR L4-S1 BILAT. LAMI. WITH FUSION TODAY. BACK DRESSING C,D,I WITH HEMOVAC COMPRESSED FOR BLOODY DRAINAGE. NEUROVASCULAR STATUS INTACT WITH 2+ PP PALP, WARM, MOBILE, COLOR WNL, + BRISK CAP. REFILL, DENIES N/T, DENIES CALF PAINS, THT/ SCD TO BILAT. LE.LUNGS CTA, ON OSA PROTOCOL, O2 AT 2L N/C, TMS# 235, NO SOB, NO C/O CHEST PAINS.ABD. SOFT, BS+, NO N/V.FOLEY WITH CLEAR YELLOW URINE.AFIBRILE, VSS. C/O LEVEL 8/10 ACHEY PAINS TO BACK WITH STATED RELIEF WITH IV DILAUDID.CONTINUE TO MONITOR.

IOM Note signed by Nada Ali Daher at 11/22/11 1402

Author: Nada Ali Daher Service: (none) Author Type: (none)
Filed: 11/22/11 1402 Note Time: 11/22/11 1219
Related Notes: Cosigned by: Shaila Gowda, MD filed at 12/13/11 1331

Beaumont Hospital - Royal Oak
Clinical Neurophysiology Department
Intraoperative Neurophysiological Monitoring Report

Patient: Gary M Locklear
ID: 2118057
Date of service: 11/22/2011
Room time: 0951

History: previous L4-L5 diskectomy in 2008 for pain in left leg. Past several months, has developed pain in right leg. Patient is diabetic.
Surgical Procedure: Posteior Transformanial Lateral Interbody Fusion. Instrumentation: AVS cage and XIA posterior
Level of Surgery: L4-S1
Technologist:N. Daher and L. Radue, CNIM
Equipment: Cascade 4

Requesting Surgeon: Dr. D. Montgomery
Interpreting physician: Shaila Gowda, M.D.

Modalities Monitored:
EMG:
Lower Extremities:
Free run
Train Of Four

Intraoperative Neurophysiological Findings:

EMG-upper/lower extremities

Continuous intraoperative EMG activity was monitored in the lower bilateral extremities from biceps femoris, vastus lateralis, gastrocnemius, tibialis anterior and abductor hallucis brevis muscle/s.

Baseline EMG responses were obtained at the beginning of the surgery and noted to be quiet.

While decompressing, a spontaneous burst of EMG activity was noted in the left gastrocnemius.

At closing, no EMG activity was observed.

Train of Four
"Train of Four" response was continuously recorded from bilateral abductor hallucis brevis muscle/s with stimulation of Posterior tibial nerve at 50 mA.

Impression:
There were no significant changes seen during the monitoring. This intraoperative neurophysiological monitoring was supervised by the attending staff neurologist. All findings were discussed with the surgeon in real time during the course of the monitoring.

A detailed monitoring report for this case is available in the IOM department.

Exhibit 16

Progress Notes

Progress Notes Info

Author	Note Status	Last Update User	Last Update Date/Time
Skolnik, Bruce J, MD	Signed	Skolnik, Bruce J, MD	3/30/2012 1:55 PM

Progress Notes

PROCEDURE DATE: 3/30/2012

SURGEON: Bruce Skolnik, MD

ANESTHESIA: Local.

PREOPERATIVE DIAGNOSIS:
The encounter diagnosis was Postlaminectomy syndrome.

POSTOPERATIVE DIAGNOSIS:
Same.

PROCEDURE:
Caudal epidural steroid injection - 62311.
Fluoroscopic guidance - 77003-26.

INDICATIONS FOR PROCEDURE: Gary M Locklear is a 61y.o. Male With a history of postlaminectomy syndrome of the lumbar spine. The patient was last seen 329 2012. At that time, caudal steroid injection #1 was performed. The patient reports positive symptomatic improvement, graded at about 70%, of right lower extremity radiculopathy. He continues to have symptomatology in the right L5-S1 nerve root distribution. Today, we are procsternal injection for continued symptomatic management: The patient denies lower extremity weakness and denies bowel or bladder dysfunction.

Heart and lung examination is unchanged from the intake examination. Risks, benefits and expectations of treatment were discussed with the patient in great detail. The patient expressed both an understanding of the risks and a desire to proceed.

OPERATIVE PROCEDURE: After discussing the risks and benefits, written informed consent was obtained. The patient was placed in the prone position. Sterile prep and drape of the sacrococcygeal region was performed in the usual sterile manner. One percent Lidocaine with bicarbonate was used for skin and subcutaneous infiltration of the sacrococcygeal area. A #18 gauge Tuohy needle was then advanced at this location to the epidural space using loss of resistance technique and fluoroscopic guidance. Identification of the epidural space was without difficulty or complication. Following negative aspiration, 4 cc of Isovue 200-M was injected which spread cephalad in the posterior aspect of the epidural space, confirmed on AP and lateral views. Then, 80 mg Depo-Medrol in 6 cc preservative-free normal saline was injected. The needle was then flushed with 1 cc preservative-free normal saline and withdrawn.

I verify that I personally performed this procedure.

DISPOSITION: The patient tolerated the procedure well without any complications and was taken to the recovery room area. The patient was monitored in the recovery area prior to discharge and discharged in stable condition with a driver.

FOLLOW UP:
Return in about 1 month (around 4/30/2012) for caudal #3.

Exhibit 17

Oakland Orthopaedic Surgeons, PLLC
30575 Woodward Avenue Royal Oak, MI 48073
(248) 280-8550 Fax: (248) 280-8571

Gary M Locklear
Male DOB: 12/12/1950 88591 Home: (248) 486-0684
371524131 Ins: Independent Claim Services Ins ID:

12/10/2012 - Office Visit
Provider: David M Montgomery MD
Location of Care: Oakland Orthopaedic Surgeons, PLLC

Gary Locklear is one year postoperative from an L4 to S1 laminectomy, fusion and TLIF procedure. He is much better than he was last year but he still has symptoms. He has mostly numbness in the right lower extremity. The excruciating pain in the leg is pretty much gone but he still has some discomfort. He is working with Dr. Bruce Skolnick at the Beaumont Pain Clinic. He takes Neurontin for the pain and Percocet.

PHYSICAL EXAMINATION:
On clinical exam, he uses a cane. He has some mild residual weakness in the right lower extremity.

X-RAY:
X-rays of the lumbosacral spine, including AP and lateral views, show a solid fusion with intact implants from L4 to S1.

PLAN:
At this point, he can gradually increase his activities as comfort allows and follow up in one year.

Electronically signed by David M Montgomery MD on 12/12/2012 at 11:27 AM

First Class Mail

Stephen B. Foley, P.C.
9900 Pelham Road
Taylor, MI 48180

Liberty Mutual Insurance Agency
CSC-Lawyers Incorporating Service
3410 Belle Chase Way, Suite 600
Lansing, MI 48911

CERTIFIED MAIL - RETURN RECEIPT REQUESTED